OFFICE OF THE MEDICAL SUPERINTENDENT SERVICES HOSPITAL
AND CIVIL SURGEON KARACHI _____

NO.SIIK (RE-IMBURSEMENT)/- _____ DATED: _____

NON-AVAILABILITY CERTIFICATE

SIGNATURE: _____

1.	NAME OF CIVIL SERVANT	
2.	Age of the Civil Servant	
3.	Father's Name of the Civil Servant	
4.	Computer Code of the Civil Servant	
5.	CNIC No. of the Civil Servant	
6.	Personal Number of the Civil Servant	
7.	Active Mobile Number of the Civil Servant	
8.	Servant Status (In Service / Retired)	
9.	DESIGNATION WITH BPS/DEPARTMENT	
10.	NAME OF PATIENT (s)	
11.	Age of Patients	
12.	RELATION WITH INCUMBENT(s)	
13.	FRC/ B-FORM	
14.	N A T U R E O F I L L N E S (e s)	Viral Fever (Son), Diabetes (Father)
15.	DESIGNATION AND PRESCRIPTIOW-OF AUTHORIZED MEDICAL ATTENDANT ARE ATTACHED, NO CLAIM WILL BE ENTERTAINED UNLESS IT IS ACCOMPANIED BY PRESCRIPTION OF AUTHORIZED MEDICAL ATTENDANT	
16.	WHETHER TREATMENT'WASTAKENAT A GOVT., HOSPITAL IF SO, ENTRY NO WITH DATE & TIME.	
17.	WHETHER TREATMENT WAS TAKEN AT GOVT. HOSPITAL IF NO WHY.	
18.	WHETHER TREATMENT WAS TAKEN AT PRIVATE HOSPITAL,. IF YES, MENTION THE REASONS.	
19.	WHETHER IT WAS EMERGENCY CASE, IF SO WAS HE REFERRRED BY WHO TO PRIVATE HOSPITAL: FOR THE REASNONS THAT. A) REASON FOR EMERGENCY. B) THE TREATMENT/FACILITY/TEST, MEDICINE WAS NOT AVAILABLE AT ANYT,GOVT:HOSPITAL (PLEASE SPECIFY TREATMENT SUGGESTED)	
20.	WHETHER ANY MEDICAL BOARD WAS CONSTITUTED _ IF YES ATTACH ITS RECOMMENDATIONS.	
21.	IN CASE OF ACCIDENT. (i)NATURE OF ACCIDENT AND INJURIES: (ii) PALACE OF ACCIDENT AND DATE	
22.	AMOUNT CLAIM BY PATIENT.	
23.	AMOUNT RECOMMENDED BY CIVIL SURGEON	

C E R T I F I C A T E

It is certified that the case was of emergent nature for which treatment was not available at any of the Government Hospital located in vicinity and delay could have risk her life and was accordingly referred to the mentioned Hospital. It is further certified that drugs/medicines prescribed by the private Hospital/ Medical Attendant to whom case was referred to, the details whereof are as under, are not available in the Government Hospital and were accordingly purchased by the claimant vide vouchers ***as per attached list/details*****/in original** amounting to aggregate as **Rs** _____ and are recommended for reimbursement.

MEDICAL SUPERINTENDENT SERVICES
HOSPITAL AND CIVIL SURGEON
KARACHI

OFFICE OF THE MEDICAL SUPERINTENDENT SERVICES HOSPITAL AND CIVIL SURGEON KARACHI

STATEMENT SHOWING THE DETAIL IN RESPECT OF MEDICAL BILLS SUBMITTED BY _____ OF THIS HONORABLE COURT

S. No.	Name of Hospital / Medical Store / Laboratory	Date	Vouchers / Invoices Numbers	Dependant	Amount
1				Self	
2				Father	
3				Mother	
4				Mother	
			Grand Total		

Rs. _____ Amount in Words_____

Certificate that the amount of the above medical bills have not been drawn before

SIGNATURE OF APPLICANT	
NAME OF APPLICANT	
DESIGNATION	
PERSONNEL NO	
CNIC NO	
CONTACT NO	
CLAIMED AMOUNT	
FOR OFFICE USE / BILLING SECTION USE ONLY	
EXAMINATION OFFICER NAME	
SCRUITNY / EXAMINATION SCRUITNY / EXAMINATION OFFICER SIGNATUREOFFICER SIGNATURE	

HIGH COURT OF SINDH KARACHI

CERTIFICATE

This is to certify that medicines / drugs purchased by the claimant and bills submitted for reimbursement are in accordance with the permission accorded by the Government of Sindh vide Office Memorandum No. FD (SR –II)-7089/213-14 dated 01st September.2015.

The bills are recommended for reimbursement

Signature	
Dr.	
High Court Clinic	
Stamp	

SIGNATURE OF APPLICANT	
NAME OF APPLICANT	
DESIGNATION	
PERSONNEL NO	
CNIC NO	
CONTACT NO	
CLAIMED AMOUNT	
FOR OFFICE USE / BILLING SECTION USE ONLY	
EXAMINATION OFFICER NAME	
SCRUITNY / EXAMINATION SCRUITNY / EXAMINATION OFFICER SIGNATUREOFFICER SIGNATURE	