CKPP-3-10-2018- 50Pads

W.U.S. HEALTH CENTRE
UNIVERSITY OF DELHI,
DELHI-110007

Dated :

Reimbursement Form for payment of Investigation Charges

S.No.	Name of Hospital/ Diagnostic Centre	Name of Investigation(s)/Test(s)	Amount
1.			
2.			
3.			
4.			

Total | **Rs.** |

Signature of employee.......................................
Name of Employee...
(In Block Letters)
Token No. ....
Designation...
Deptt/College..
Mobile/Telephone No...
Address...
....

Bank Details :

Saving Bank A/c No.	Bank Name	Branch	IFSC Code

Please attach :-

- Original prescription slip of W.U.S. Health Centre.
- Original bill of Hospital/Laboratory/Diagnostic Centre.
- Photocopy of report(s).
- Photocopy of first page of Bank Passbook/cancelled cheque.