शिक्षा निदेशालय उच्चतर

27 AUG 2019

Copy of Notification has been received from the Additional Chief Secretary (Health) to the Government of Himachal Pradesh vide letter No. HFW-B(A)8-1/2003-Loose dated 09.08.2019 and endorsed all the concerned Departments in Himachal Pradesh.

NOTIFICATION

The Governor, Himachal Pradesh is pleased to notify the Chronic disease certificate as per Annexure-A for considering proposals for change of option as per the provisions contained at serial number-4 of this department letter No. HFW-B (A) 12-9/79 dated 21.-06-1996.

By Order

Sd/-
Additional Chief Secretary (Health) to the
Government of Himachal Pradesh.

(Budget & Accounts Branch)

Endst.Even. No. EDN-HE (4)3(C) 2016-17-Vol-I (Med.Option) the, 27 August, 2019.

Copy forwarded for information and further necessary action to the:

1. The Additional Director of Higher Education, (College) H.P. Shimla-1
2. The Joint Director of Hr. Education Admn./C-1/C-11) H.P. Shimla.
3. All the Branch Officers, Directorate of Higher Education, H.P.
4. All the Principal Govt. College & Sanskrit College Himachal Pradesh.
5. All the Branch Supdts., Directorate of Higher Education, H.P.
6. The PA to DHE, H.P. Shimla-1
7. The Librarian, Central State Library, H.P.
8. All the Librarian, Distt. Libraries in Himachal Pradesh.
9. The Group Commander, NCC Gp HQ Shimla & Solan H.P.
10. All the Deputy Directors of Higher Education, Himachal Pradesh, you are directed to issue this instruction to all the DDO's under your control immediately. This notification is available on the website of the Department website www.educationhp.org.
11. The Incharge, IT Cell (Internal) to upload this notification on Department website, please.
12. Guard file.

Director of Higher Education
Himachal Pradesh.

27 AUG 2019

CHRONIC DISEASE CERTIFICATE

(For change of option for Medical Allowance in respect of Himachal Pradesh Government Employees/Pensioners and their dependents)

Sr. No. _____ Date _____

Name & Address of Hospital

_____

_____

CR/IP No _____

Photograph
(duly attested)

Certified that I have examined

Mr./Ms. _____

Son/ Daughter/ Husband/ Wife of _____

Age _____ years, resident of _____

_____

_____ Village/City/Town _____

Distt. _____ today on _____.

He/She is suffering from _____ which is a chronic and a grave disease. I am of the opinion that he/she will require prolonged outdoor treatment and costly medicine for restoration of health. I recommend this case for change of option from fixed Medical Allowance to open medical reimbursement.

Signature of patient examined

Name & Signature of the
Specialist Doctor(s)
(with seal)