PROFORMA – 'A'

Application for General/Special Scholarship for Technical Education

The Chairman,
DSBF Committee,
Secunderabad Division,
South Central Railway.

1	Name of the employee in full (in Block letters)	
2	Name of the Father/Husband	
3	If spouse is a Railway/Government Employee, details thereof	
4	Date of Appointment	
5	Bill Unit No	
5	Designation, Office & Station	
6	7. P. F. Number	
8	Telephone Number(RLY) & MOBILE Number	
10	Pay Level (Grade Pay) & Basic Pay	
12	Name of the Scholar ward & Relation ship	
14	Course Studying	
15	Year of Study in during the Academic Year 2018-19 viz., 1st Yr, 2nd Yr, 3rd yr, 4th Yr etc.,	
16	Name of the Institution where studying	
17	Whether the child is in receipt of any other scholarship and it so, the value.	
18	Whether the child is exempted from payment of term/tuition fee and if so, the value.	
19	Whether the student is employed and is having his/her own resources.	

I hereby declare that all the particulars furnished above are true and I am liable for disciplinary action, if they are proved to be incorrect at a later date. I also declare that the student Master/Kumari……...Is related to me as …….

Date:

Place: Signature of the employee

Cont. ..2

In case, where the student is a dependent on the employee, the following declaration needs to be submitted.

Witnesses:
We hereby declare that the particulars furnished by

Shri./Smt. _____ Designation _____
are correct to the best of my knowledge:

S. No.	Name (in BLOCK LETTERS)	Designation/Office/ Station	Signature
01			

The details mentioned in Col. No.12 is hereby certified. The said scholar ward has been included as a dependent in the pass declaration submitted by the employee.

Signature & Designation of the Pass Issuing Officer.

No. Office
Date Station:

Forwarded, It is certified that the particulars furnished against item 1 to 10 have been verified and found correct.

Signature & Stamp of the Controlling Officer

Documents to be enclosed to the application:

1. Attested copy of the Mark Lists of the Qualifying Examination, viz., the exam passed in the all Academic Years.
2. Certificate from the College of study on Fee Payment.(Annexure)
3. Pay Slip & ID Card photo copy of the employee.

**** Please note that no column should be left blank. The telephone number should be furnished.**

ANNEXURE

Name of the college with seal.
Affiliated to :

CERTIFICATE

This is to certify that Kum./Master_____

Son/Daughter of Shri_____, is/was a student

of this college studied/studying in _____ (course)_____

(Year of study –1st Yr, 2nd Yr, 3rd Yr, 4th Yr etc.,) during…….

2. The student has remitted an amount of _____

(Rupees_____only)

towards college fee during the said Academic Year 20……-20……. **It is also certified that the student is NOT EXEMPTED from payment of FEE and is also not in receipt of any SCHOLARSHIP from any other sources.**

It is also certified that the student has completed all academic years successfully, without any backlogs.

4. This certificate is issued to the student to enable her to obtain SCHOLARSHIP from the Staff Benefit Fund of the Railways.

Signature of the Authorized Signatory with College Seal

PLACE:
DATE:

PROFORMA – 'E'

GRANT OF CASH AWARDS FOR MERITORIOUS WARDS OF RAILWAY EMPLOYEES FOR ACHIEVING ACADEMIC EXCELLENCE

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
1(b)	If spouse is a Railway/Government employee, details thereof.							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
8	Name of the student in whose favour the Cash Award is sought for				Relationship with the employee			
9	Course Completed							
10	Year of Completion							
11	Name of the Institution where studied							
12	Nature of Academic Excellence achieved							

I hereby declare that all the particulars furnished above are true and correct and I have enclosed copies of relevant certificates issued by the University in this regard. I also understand that the submission of the application does not automatically entitle my son for the award.

Date:
Place: Signature of the employee

Forwarded to the Chairman, HQ SBF Committee & CPO for a consideration.

Signature of the Controlling Officer with Stamp

PROFORMA 'F'

Application for Maintenance Grant

To
The Chairman,
DSBF Committee
Secunderabad Division,

TELEPHONE NUMBER
Railway :
Mobile :

Sir,

I have been sick from……..and without pay from ……Please therefore sanction maintenance grant in my favour. Particulars required are furnished below.

Period of sickness as in patient……..

Period of sickness as out patient ……

Date: …….

Yours faithfully,

Signature of the Applicant

(to be filled in by the office where the applicant i.e. working)

1	Name of the employee in full (in Block letters)						
1(a)	Son of / Wife of (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Period of Sickness				From	To	
A	With Pay						
B	With Half Pay						
C	Without Pay						
9	Sick Certificate Number & Date						
10	Sick Certificate issued by (Designation of the Railway / Govt. Medical Officer						

Cont..page 2

Forwarded to DMO/…….. It is certified that the particulars given above are correct. He has already been paid maintenance grant for the period from …….. to ……vide sanction letter No. …….. dated …….

Office/station

Controlling Officer
Designation Stamp to be affixed

Memo No. Dat e Office/Stn

Recommended. The employee is on Sick List from _____ to _____ vide M 8 B Certificate No. _____ Dated _____

Period of Sickness as in patient: From: To:

Period of Sickness as out patient: From: To:

Nature of illness:
(Common name as can be understood by Non-Medical Staff Should be given)

Divisional Medical Officer
(Signature with Stamp)

ANNEXURE – 'G'

Application for Grant of Medical Assistance for Major Diseases and Chronic Cases involving Major Operation.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
8.	For whom the assistance is applied for							
9.	Name of the dependent & Relationship, If the assistance is for dependent							

Date: Signature of the employee.

Memo No. Office
Date: Station:

Forwarded, it is certified that the particulars given above are correct.

Controlling Officer.
(Designation Stamp)

Memo No. Date:
Office:_____
Station:_____

Recommended. Certified that the employee/dependent family member named has undergone major operation for on and is suffering from which is major disease/chronic case. She / He is/was under treatment from . to

(Strike off whichever is not applicable)

Divisional Medical Officer,
(Designation Stamp to be affixed)

PRFORMA 'H'

Application for Reimbursement of the Cost of Spectacles

TELEPHONE NUMBER

The Secretary, Railway :
South Central Railway, Mobile :
HQrs. / Divisional / Workshop SBF Committee,

I hereby apply for the reimbursement of the cost of spectacles purchased by me.

1	Name of the employee in full (in Block letters)(a) DATE OF BIRTH						
	(b) S/o / W/o (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation			Office/Station			
5	Department/Division			P. F. Number			
6	Pay in Pay Band			Running Allowance			
7	Grade Pay Substantive			Grade Pay Officiating / MACP			
8	Whether applied previously, if so, when & what is the result						
9	Receipt Number & Date (ORIGINAL RECEIPT to be enclosed)						
10	Cost incurred in the purchase						

I declare that I have not claimed reimbursement of cost of spectacles during the last 02 / 03 Financial Years. The particulars furnished by me above are true and I am liable for disciplinary action if proved untrue.

Encl: Yours faithfully

Date:
Station: Signature of the Applicant

Memo Office:
Date:

Forwarded to DMO/……. It is certified that the particulars given against 1 to 10 are correct.

Controlling Officer.
(with Office Stamp)

Memo No.
Office

Date:

Forwarded
The spectacles/change of spectacles are necessary for proper vision.
This employee is required to keep a pair of spectacles on duty
(Strike off whichever is not applicable)

Divisional Medical Officer.
(Designation Stamp)

PROFORMA 'I'

Application for grant of financial assistance from SBF for the children of Railway employees attending Schools for Deaf, Dumb, Blind and Mentally retarded.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

1	Name of the employee in full (in Block letters)						
1(a)	Son of / Wife of (In case of female employee)						
1(b)	If spouse is a Railway/Government employee, details thereof						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Name of the Deaf, Dumb, Blind or mentally retarded child						
9	Relationship						
10	Date of Birth & Age of child						
11	Name of the School for Deaf, Dumb, Blind or Mentally retarded and place where the student is studying and residing in without fail.						
12	a)Amount of tuition fees paid per month						
	b) Amount of Transport charges paid per month.						
	c) Amount of residential fees paid per month.						
13	Grant of SBF received upto						
14	Amount now claimed:						
	a) Period of claim (From – To)						
	b) Tuition fees						
	c) Residential fees						
	d) Conveyance charges incurred						
15	Whether Vouchers/stamped receipts enclosed.						
16	Whether the students is in receipt of any financial aid from any other source for this purpose, if so, full particulars						

Cont..Page 2

The particulars mentioned above are true and the amounts received in this respect will be refunded, if the same are found incorrect. I also declare that the child for whom the FA is sought from SBF is not in receipt of the Children Education Allowance (Re-imbursement of Tuition Fee).

Date Signature of the applicant

Certified that the particulars furnished against columns 6 to 11 are correct and that the child (name)……..is a bonafide student of this Institution studying in ……class. The duration of his/her course of studies extends upto _____. He/She is not in receipt of any scholarship/Stipend/Reimbursement from any other source. His/her conduct and progress is satisfactory.

The tuition fees/residential fees referred to above are recommended as these are essential for the prosecution of studies in the Institution.

Seal of the Institution Signature of the Principal

Place:_____ Name of the Institution

Date: _____

Memo No. Date: Office of the

Forwarded to DMO _____

The particulars furnished against columns 1 to 5 are correct.

Signature of the Controlling Officer
Designation

Memo No. Office:_____
Station: _____
Division: _____

Forwarded to the Secretary, Headquarters SBF Committee, CPO's Office, SC for necessary action.

The above particulars furnished by the employee are correct and the case is recommended for sanction.

Divisional Medical Officer.

PROFORMA 'J'

Application for sanction of financial assistance in favour of Physically Handicapped and School going Children of Railway Employees.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

I hereby apply for financial assistance for my Physically Challenged School going son/daughter to cover the cost of transport from residence to school & back. Necessary particulars are furnished below:

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
1(b)	If spouse is a Railway/Government employee, details thereof.							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
8	Name of the Physically Challenged student ward in whose favour the scholarship is sought for				Relationship with the employee			
9	Date of Birth of the School going Child				Class studying			
10	Name of the School in which studying at present.							
11	Nature of physical disability							
12	Financial assistance from SBF received upto							
13	Period for which Financial assistance is now claimed (From – To)							

The particulars furnished above are true and the amount received in this respect will be refunded if the same are found incorrect.

Date: Signature of the applicant.

No. Date:

Certified that the particulars furnished against columns 8 TO 11 are correct and the child Master/Kumari. Is/was bonafide student of this institution studied last year in Class and at present studying in class academic year 20 . It is also certified that the student is a physically handicapped person.

Signature of the Headmaster
Name of the Institution (Stamp)

Memo No. Date Office

Forwarded to DMO …… The particulars furnished against columns 1 to 8 are correct.

Office seal:

Signature of the Controlling Officer.
With Designation Stamp.

Memo No. Date Office

Forwarded to the Secretary, HQrs. SBF Committee, CPO's Office/SC for necessary action.

It is certified that ……son/daughter of Shri …….. is a physically handicapped person.

The nature disability…….

Divisional Medical Officer with stamp

PROFORMA 'K'

Application for Grant of financial assistance for loss of property on Accountof Fire, Flood and Cyclone

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

1	Name of the employee in full (in Block letters)						
1(a)	Son of / Wife of (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Nature of loss sustained						
9	Date of occurrence						
10	Financial loss sustained in detail						
11	Certificate from the Police or Civil authorities						
12	Whether any financial assistance is received from State Govt. & if so the amount received.						

DA: Certificate
Date:

Signature of the employee.

Memo No.

Office:_____
Station:_____
Date: _____

Forwarded, it is certified that the particulars given above are correct and correct and I recommend/do not recommend this case for financial assistance for sanction..

Controlling Officer.
(Designation Stamp to be affixed)

ANNEXURE- L

Application for grant of Financial Assistance to the families of employees who die while undergoing treatment at RAILWAY/ REFERRAL Hospitals.

***

My husband/wife/father/mother, who is a serving Railway employee has died while under treatment at Central Hospital, Lallaguda / Referral Hospital, RH/BZA; GTL; GNT; NED; Poly clinic/ KZJ; . His/ Her details are as under:

Name of the deceased employee (in Block letter)	Designation & Station	Division/ Unit	P.F Number	Date of Death	Address where the last rites are to be performed

I request that Financial Assistance, as due and admissible may be paid to me from HQ SBF.

Signature/LTI of the Applicant

Name :
(in BLOCK LETTER)
Relationship with
The deceased :

No. Office:

The family of the deceased employee is entitled for a FA of ` 10,000/ ` 5,000 from HQ SBF. The same may please be sanctioned.

OS/Railway Hospitals

Sr. MS/Admn./In charge Physician

Received an amount of ` 10,000/ ` 5,000 from MD/CH/LGD/CWS (BZA; GTL;GNT;NED) Sr. MS/KZJ.

The payment has been made in on Signature of the receiver
Presence:

Sl. No	Signature	Name & Designation
1		
2		

PROFORMA 'M'

APPLICATION FOR GRANT OF CASH INCENTIVE FOR ADOPTING SMALL FAMILY NORMS AFTER ONE GIRL CHILD OR ONE MALE/TWO FEMALE CHILDREN.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

I hereby apply for grant of cash incentive for adopting small family norms after one girl child or one male/two female children. Necessary particulars are furnished below:

1	Name of the employee in full (in Block letters)						
1(a)	Son of / Wife of (In case of female employee)						
1(b)	If spouse is a Railway/Government employee, details thereof.						
1(b)	Date of Birth						
2	Date of Appointment			Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation			Office/Station			
5	Department/Division			P. F. Number			
6	Pay in Pay Band			Running Allowance			
7	Grade Pay Substantive			Grade Pay Officiating / MACP			
8	Family composition						

S. No.	**Name of the dependent**	**Relationship**	**Age/DOB**	**Remarks**
9	Number of living children (on the date operation)	MALE	FEMALE	TOTAL
10	Sterilization operation particulars.	Date of operation	Hospital/Clinic where the sterilization operation was performed	

(Note: In case the operation was done in a private Hospital, the certificate should be got countersigned by the Railway Doctor. In other cases, the copy of the certificate should attested by a Railway Officer).

Signature of the employee

DECLARATION

I hereby declare that the particulars furnished above are true complete and correct to the best of my knowledge and belief and that no fact has been concealed to derive the incentive from SBF. I also declare that the above incentive has not been claimed by my spouse (in case the spouse of the employee is also a Railway employee) / my spouse is not employed on Railways.

I fully understand that should the information provided by me is found to be incorrect at a later date, the amount granted to me is fully recoverable from my salary and I shall not take legal recourse to avoid such recovery. I am also aware that I am liable to be taken up under D&A Rules in case the information provided by me is found to be false/incorrect.

Place:
Date: Signature of the employee

We, the co-employees of Shri……
Design……Station……. Hereby certify that the information furnished by Shri ……. Is true complete and correct to the best of our knowledge. We also certify that the declaration has been signed by Shri …….. in our presence.

S.No.	Name	Designation	Office/Stn.	Signature

No. Office

Station

Date:

Forwarded to Chairman/HQrs. SBF Committee & CPO/SC for necessary action. The particulars furnished by the employee have been verified with the Service Register / Pass Declaration of the employee and found to be IN ORDER.

Signature
Design. & Stn.
(with office seal)

PROFORMA 'N'

APPLICATION FOR RE-IMBURSEMENT OF 50% EXPENSES INCURRED ON TREATMENT IN NATUROPATHY

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

I hereby apply for re-imbursement of 50% expenses incurred on treatment in naturopathy, in favour of myself/my family member covered under RS(Pass)Rules. . Necessary particulars are furnished below:

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
1(b)	Date of Birth							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
8	Details of the family member who underwent the treatment in Naturopathy							

S. No.	**Name**	**Relationship**	**Age/DOB**	**Remarks**

9	Name & Address of the Hospital/Institution where the treatment was taken	
10	Whether the Hospital/Institute is recognized by the Government, if so the details of the Govt. G.O (a copy of the G.O. should be enclosed in support	
11	Amount incurred towards treatment (ORIGINAL BILLS in support should be enclosed)	

Signature of the employee

DECLARATION

I hereby declare that the particulars furnished above are true complete and correct to the best of my knowledge and belief and that no fact has been concealed to derive the incentive from SBF. I also declare that I have not claimed the above grant in my favour/in favour of the family member for whom this is claimed. I also declare that the family member for whom the claim has been made is fully dependant on me and is also included in my PASS DECLARATION. I am fully aware that I would not be eligible to claim the grant in favour of myself/my dependant in whose favour the claim is made.

I fully understand that should the information provided by me is found to be incorrect at a later date, the amount granted to me is fully recoverable from my salary and I shall not take legal recourse to avoid such recovery. I am also aware that I am liable to be taken up under D&A Rules in case the information provided by me is found to be false/incorrect.

Place:
Date: Signature of the employee

We, the co-employees of Shri……
Design……Station……. Hereby certify that the information furnished by Shri ……. Is true complete and correct to the best of our knowledge. We also certify that the declaration has been signed by Shri …….. in our present.

S.No.	Name	Designation	Office/Stn.	Signature

No. Office

Station

Date:

Forwarded to Chairman/HQrs. SBF Committee & CPO/SC for necessary action. The particulars furnished by the employee have been verified with the Service Register / Pass Declaration of the employee and found to be IN ORDER.

Signature
Design. & Stn.
(with office seal)

- **PRFORMA 'O'**

Application for Reimbursement of the Cost of Dentures

TELEPHONE NUMBER

The Chairman,
DSBF Committee,
Secunderabad Division,

Railway :

Mobile :

I hereby apply for the reimbursement of the cost of Dentures .

1	Name of the employee in full (in Block letters) (a) DATE OF BIRTH						
	(b) S/o / W/o (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Whether the dentures have been recommended by the Railway Medical Authorities?						
9	Receipt Number & Date (ORIGINAL RECEIPT to be enclosed)						
10	Cost incurred in the purchase						

I declare that I have not claimed reimbursement of cost of dentures earlier and the particulars furnished by me above are true and I am liable for disciplinary action if proved untrue.

Encl:

Yours faithfully

Date:
Station:

Signature of the Applicant

Memo

Office:
Date:

Forwarded to DMO/……. It is certified that the particulars given against 1 to 7 are correct.

Controlling Officer.
(with Office Stamp)

Memo No.

Office
Date:

Forwarded

The employee requires replacement of his tooth/Dentures. The employee has got the tooth/dentures fixed and the replacement is satisfactory.

Divisional Medical Officer.
(Designation Stamp)

RFORMA 'P'

Application for grant of Financial Assistance for procurement of Wheel Chair/Prosthesis/Artificial Limbss

TELEPHONE NUMBER

The Secretary, Railway :
South Central Railway, Mobile :
HQrs. / Divisional / Workshop SBF Committee,

I hereby apply for financial assistance from SBF for procurement of Wheel Chair/Prosthesis/Artificial Limbs.

1	Name of the employee in full (in Block letters) (a) DATE OF BIRTH						
	(b) S/o / W/o (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Nature of Disability and the % thereof (Attested copy of the Certificate issued by the Govt. Civil Surgeon to be enclosed)						
9	Whether the said implement is provided by agencies recognized by the Government (List of agencies given overleaf). If so, the rate quoted by them (Quotation obtained should be enclosed in ORIGINAL).						
10	Cost of the Wheel Chair/Prosthesis/Artificial Limbs as indicated in the quotation.						
11	In case the Agencies mentioned do not manufacture the said implement, the name of the Agency from whom the implement is likely to be purchased.						
12	Rate quoted by the outside agency (Quotation to be enclosed in ORIGINAL).						

I declare that the details as above are true, complete and correct and I am fully aware I am liable for disciplinary action if proved untrue.

Encl: Yours faithfully

Date:
Station: Signature of the Applicant

Memo

Office:
Date:

Forwarded to Sr. DMO/Ortho, CH/LGD. The employee is hereby directed. It may please be certified as to whether the implement sought by the employee would be helpful to him. The Sr. DMO/Ortho may record his recommendations underneath.

Controlling Officer.
(with Office Stamp)

Memo No.

Office
Date:

Verbatim recommendations/observations of the Sr. DMO/Ortho, CH/LGD

Sr. Divisional Medical Officer/Ortho.
Central Hospital/Divisional Hospital
(Designation Stamp)

Forwarded to the Chairman, HQ SBF Committee & CPO. The recommendations of the Sr. DMO/Ortho are hereby accepted. The Differently abled employee may be provided financial assistance as sought for from the SBF for procurement of Wheel Chair/Prosthesis/Artificial Limbs.

Member, HQ SBF Committee
& CMD/SC

List of Government / Approved agencies manufacturing Artificial Implements:

(a) Sweekar Multi Speciality Rehabiliation Centre, Secunderabad (Opposite Jubilee Bus Station).

(b) Gandhi Hospital, Secunderabad.

(a) Artificial Limb Centre, PUNE.