Joint Declaration Form

We _____, Department of _____

_____ and Smt./Miss/Shri _____

_____ Division / Branch/ Section _____ ____

will claim all the medical expenses and L.T.C. incurred on them and their family members from the Department of _____ _____.

DEPENDENT FAMILY MEMBERS

Sl. No.	Name	Date of Birth/Age	Relation
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Signature of Husband/Wife Name	Signature of Applicant Name
Designation	Designation
Deptt.	Deptt.
Office Seal	Office Seal
Date	Date