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.			
5.			
6.			
T O T A L			

Name of Employee (In Block Letters)……..……...…….…… Designation……

Department/College……..…… Token No. ……..…

Address……..…….Mobile Number …….

Bank Details :

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

Signature of employee

Please attach :-

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