प्रारूप – जी.ए.आर. 23 / Form G.A.R.23
नियम 91 / Rule 91
चिकित्सा व्यय प्रतिपूर्ति बिल / Medical Charges Reimbursement Bill

बिल सं. एवं तारीख ______________________________

कार्यालय निदेशक, इं.गां.रा.व.अ. दे.दून / O/o- The Director, IGNFA, DDN

माह/For the month of ______________________ वर्ष/Year 20 __________

लेखा शीर्ष/Head of Account मेडीकल/Medical योजना/गैर-योजना Plan/Non-Plan

क्र.सं.	अधिकारी का नाम Name of Incumbent	पदनाम Designation	सकल दावा Gross Claim	अग्रिम की वसूली Recovery of Advance	शुद्ध रकम Net Amout	टिप्पणी Remarks
1	2	3	4	5	6	7

भुगतान की जाने वाली शुद्ध राशि (शब्दों में) / Net amount required for Payment (in words) ______________________

1. प्रमाणित किया जाता है कि मैं इस बात से संतुष्ट हूं कि अधोवर्णित (जिनकी समस्त राशि इस बिल से काटकर जमा कर दी गई है) के अतिरिक्त अब से 1/2/3 माह पूर्व आहरित बिलों में दी गई राशि का संवितरण उनमें दिए गए सरकारी कार्मिकों के बीच कर दिया गया है और उनकी रसीदें बिल की कार्यालय प्रतियों में हैं। **Certified that I have satisfied myself that the amount included in the bills drawn 1/2/3 months previous to the date, which the exceptions of those detailed below (of which the total amount has been refunded by deduction from this bill) have disbursed to the Government servants therein named and their receipts in office copies of the bill.**
2. प्रमाणित किया जाता है कि अनिवार्यता प्रमाणपत्र, रसीदें आदि संलग्न हैं / Certified that Essentiality Certificates, Receipts, etc. are appended.

20………. हेतु विनियोजन /Appropriation for 20……………

रु. .... के लिए पास किया गया और रु. .... का भुगतान किया गया।

Passed for Rs..______________________ And Pay Rs. (______________________________)

आहरण एवं संवितरण अधिकारी के हस्ताक्षर
Signatures of DDO

प्रतिहस्ताक्षर / Counter Signatures of
प्राध्यापक (प्रशा.) / अपर निदेशक / निदेशक
Professor (Admn.)/Addl. Directro/Director

Form-G.A.R. 23

Rule 91

Medical Charges Reimbursement Bill

Bill No. and Date ______________________________

Office of the Director IGNFA, Dehradun.

For the Month of ______________________ Year 20 __________

Head of Account Medical Plan / Non-Plan

S. No.	Name of Incubment	Designation	Gross Claim	Recovery of Advance	Net Amount	Remakrs
1	2	3	4	5	6	7

Net amount required for Payment (in words) ______________________________

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1. Certified that I have satisfied myself that the amount included in the bills drawn 1/2/3 months previous to the date, with the exeption of those detailed below (of which the total amount has been refunded by deduction form this bill) have disbursed to the Government servants therein named and their receipts in office copies of the bill.
2. Certified that Essentiality Certificates, Receipts, etc. are appended.

Appropriation for 20 ______________ Passed for Rs. ______________

And Pay Rs. (______________________________)

Signature of DDO

Counter Signature of
Professor (Admn.)/Addl. Director/Director