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) _____

_____

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