FORM OF APPLICATION FOR GRANT OF SUBSISTANCE ALLOWANCE TO THE DEPENDANTS OF MINE/BEEDI WORKERS UNDER THE DOMICILIARY TREATMENT OF T.B. SCHEME

To,
The Welfare Commissioner,
Labour Welfare Organisation,
Bhubaneswar

1.	Name and Address of the worker	:	
2.	Name and address in full of the mine/beedi establishment where the worker is employed.	:	
3.	Designation or the nature of his/her employment.	:	
4.	The date of his/her employment and period of service in mine/beedi establishment before contacting T.B.	:	
5.	His/her monthly salary / wages (excluding bonus).	:	
6.	If he/she (patient) is getting any financial assistance from any mine management/Beedi establishment or from any source. If so state the amount with period.	:	
7.	Number of dependant of the mine/beedi worker (patient) dependants including wife/husband/un-married children and step children residing with and wholly dependant on the worker.	:	
8.	Name, age, marital status and relationship of each dependant.	:	
9.	Name and address of the dispensary/hospital where the worker is being treated.		
10.	Certificate of the manager of the mine/Beedi establishment / District Magistrate/Headman of the village.	:	

Date : **Signature of the worker.**

Certified that the statement made by the applicant against the item 1 to 8 been verified and found to be correct.

Manager / Agent/Owner of the mine/
Beedi establishment.
Seal

II CERTIFICATE OF THE MEDICAL OFFICER OF THE LABOUR WELFARE ORGANISATION

Certified that the statement of the applicant against item-9 is correct. He/she is/has been receiving regular treatment from dispensary/Hospital ....

Signature
Designation
Office stamp

CERTIFICATE OF THE TREATING MEDICAL OFFICER

Certified that Shri/Smt ....Son/daughter/wife of .... Village .... P.O .... Dist .... employed as Beedi worker in the Beedi company and whose signature is given here suffering from TB of .... and was receiving regular treatment from dated .... to .... from District/Sub-Divisional Hospital / PHC .... His/her registration No. is .... dated .... of .... PHC/Sub-Divisional Hospital/District H.Q. Hospital. After receiving treatment from .... He has been examined by me today and hereby declare fit to resume his work.

Signature of the worker.
Date :

Signature of the Medical Officer
Name and Designation
Seal

Counter Signature of the Fund Medical Officer

CERTIFICATE REGARDING EMPLOYMENT STATUS

It is certified that Sri/Smt .... of Village.............................. P.o................................., Dist.. is the only learning member of his family & has no other source of income.

Competent Authority
Name :
Signature & Seal

N.B.: The Competent Authority in this case is Employer or Sarpanch or Muncipality Chairman

It is also certified that no wage is paid during the period of his/her treatment from...................... to...............

It is Certified that Sri /Smt.. of village.. employed as .... got no wage from .... to ....

Name and Employer
Signature & Seal