भा.कृ.अनु.प- केन्द्रीय मीठाजल जीवपालन अनुसंधान संस्थान
I.C.A.R-Central Institute of Freshwater Aquaculture
कौशल्यागंग, भुवनेश्वर-751002, ओड़ीशा
Kausalyaganga, Bhubaneswar-751002, Odisha

F. No. 63 (1)/CGHS/2023-24/Estt.I(e-file:86671) /1699 Date:04.01.2024

CIRCULAR

All the permanent employees and Pensioners of ICAR-CIFA are hereby informed that application in prescribed format (attached) is invited for issuance of Employee Medical Identification Card/Pensioner's Medical Identification Card for cashless facilities/credit facilities to ICAR-CIFA employees (including dependents) and Pensioners (including dependents) in Hospital which have been recognized by ICAR-CIFA. Accordingly, the duly filled-in application form may be submitted before this office on before **16th February, 2024** for further process of the said purpose.

This is issued with approval of the Director.

(M. K. Mohapatra)
Asst. Administrative Officer

Encl. As above
Distribution:

1. All the Heads of Divisions, ICAR-CIFA, Bhuaneswar
2. CAO/F&AO/DDO/Security Officer/Vigilance Officer, ICAR-CIFA
3. OIC, Dispensary, ICAR-CIFA, Bhuaneswar
4. All Section-in-Charge, ICAR-CIFA, Kausalyaganga
5. Head-cum-Sr. Sc, KVK, Khordha, Kausalyagang, Bhubaneswar.
6. PS to Director, ICAR-CIFA, Kausalyaganga, Bhubaneswar
7. Notice Board
8. Guard File.

भाकृअनुप- केन्द्रीय मीठाजल जीवपालन अनुसंधान संस्थान
ICAR - Central Institute of Freshwater Aquaculture
कौशल्यागंग / KAUSALYAGANG, भुवनेश्वर / BHUBANESWAR-751002

FAMILY DECLARATION FORM FOR MEDICAL IDENTIFICATION CARD

All fields are mandatory

A. 1. Name of the Employee / Pensioner : _____

2. Date of Birth (DD-MM-YYYY) : _____

3. Date of Joining (DD-MM-YYYY) : _____

4. Designation / Date of Retirement : _____/_____

5. Blood Group : _____

6. Mobile No. : _____

7. FMS-MIS ID No. / Div. /Sec. Ph. No : _____/ _____

(Only Employee)

8. Basic Pay : _____

9. PPO. No. : _____

(If Retirement Person)

****. A- Aadhaar Card copy is mandatory and copy of Birth / School Certificate in cases of small children should be compulsorily attached for whom AADHAAR is not done. Along with recent passport size colour photograph for self & dependent family members (two copies each) to be attached.***

B. Name of the Wholly Dependent(s) Family member's Details :
Married daughter & above 25 years son are not eligible – strictly.

Sl. No	Name of the Dependent Family Members	Relationship	D. O. B	Occupation	Marital Status	Place of residing	Income from all sources per month
1							
2							
3							
4							

C. When both husband and wife are employed :

(a) Is spouse of the employee a Government Servant ? YES / NO (Strike off which is not applicable)

(b) If Yes, than name of the Office / Organization _____
(If Yes, please attach the joint declaration)

He / She has undertaken not to avail the medical facilities provided by the said organization and a certificate / joint declaration to that effect duly counter signed by his / her employer is attached.

10. Religion :- _____

11- ***Address: - Any One***

Permanent Address	Correspondence Address

UNDERTAKING

1. It is certified that the income of dependent family members (Other than spouse) do not exceed Rs.9000/- pm. Plus the amount of Dearness Relief on basis pension of Rs.9000/- pm per person from all sources including pension / salary / business / service etc.
2. In the event of any change in the above filled particulars, in due course the same shall be intimated to the office for updating.
3. The particulars of dependent family members of my family as given in the form are correct and true to the best of my knowledge and belief. No information has been concealed or misrepresented by me.
4. I hereby undertake to keep the above particulars up to date by notifying to the Head of the Office for any addition or revision.
5. In the event of my transfer / retirement / death, I will surrender the Card to the Competent Authority.

If any information is found wrong, incorrect / false at any stage, I understand that I am liable for stringent disciplinary action and I will refund all the reimbursement made to me or my favour to ICAR-CIFA with interest and penal interest.

Date:

Signature of the Employee / Pensioner

Documents attached

1. Pensioner's PPO Book Xerox Copy

2. Passport Size Photo (Single-Single)

3. Aadhar Xerox Copy

If applicable

** The copy of self-attested documents in support of DoB along with recent passport size colour photograph for self & dependent family members (two copies each) to be attached

Indian Council of Agricultural Research
(Deptt. Of Agricultural Research & Education)
Ministry of Agriculture & Farmers' Welfare, Govt. of India
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JOINT DECLARATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES
(IN CASE BOTH GOVT. EMPLOYEES)

DECLARATION BY HUSBAND

I _____ hereby declare that my wife Smt. _____ is working in _____ as _____. I also declare that I will avail all the benefits of Medical Facilities from my Office/from the Office of my wife for myself and my family members as mentioned as below:

Sl. No.	Name	Relationship
1.		
2.		
3.		
4.		

Signature of Employee:_____
Designation : _____
Date: _____

DECLARATION BY WIFE

I _____ hereby declare that my husband Shri _____ is working in _____ as _____. I also declare that I will avail all the benefits of Medical Facilities from my Office/from the Office of my wife for myself and my family members as mentioned as below:

Sl. No.	Name	Relationship
1.		
2.		
3.		
4.		

Signature of Employee:_____
Designation : _____
Date: _____

Note

1. Acceptance of the declaration by the Competent Authority in the spouse's office should be submitted along with the Declaration falling which it would be accepted.
2. In case of any change in future the same should also be intimated jointly

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Kausalyaganga, Bhubaneswar-751002, Odisha

EMPLOYEE MEDICAL IDENTIFICATION CARD

NAME OF THE EMPLOYEE:-

DESIGNATION:

FMS-MIS/ERP No.-

Blood Group:-

Aadhaar No.

D.O.B:

Date of Retirement:

CONTACT NO.:

Address:

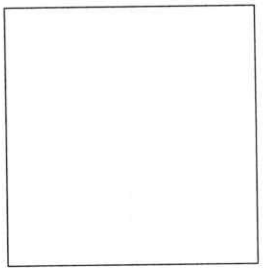
Photo of the Employee

Health Card No.

ENTITILEMENT:

Signature of Director

DEPENDENTS OF THE EMPLOYEE

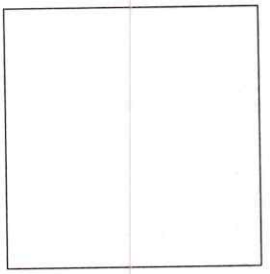


Name:

RELETIONSHIP:

D.O.B.:

AADHAAR NO.:XXXX XXXX .....

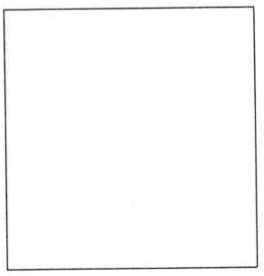


Name:

RELETIONSHIP:

D.O.B.:

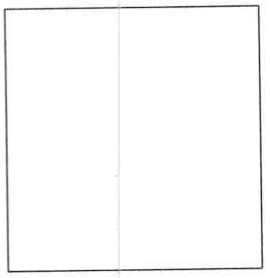
AADHAAR NO.:XXXX XXXX .....



RELETIONSHIP:

D.O.B.:

AADHAAR NO.:XXXX XXXX .....



RELETIONSHIP:

D.O.B.:

AADHAAR NO.:XXXX XXXX .....

Signature of Director

INSTRUCTIONS :-

This Card may be surrendered on retirement/death/transfer of the Employee to other Institute to the issuing Authority. If lost, the loss should be reported immediately to the Head of Office, ICAR-CIFA, Bhubaneswar, Odisha as well as nearest Police Station.

Loss Penalty is ₹200/- (Rupees Two Hundred only)

Contact : 0674-2465421/2465446

Email: director.cifa@icar.gov .in

Indian Council of Agricultural Research

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Kausalyaganga, Bhubaneswar-751002, Odisha

Pensioner's Medical Identification Card

NAME OF THE PENSIONER:-

DESIGNATION:

P.P.O. No.-

Blood Group:-

Aadhaar No.

D.O.B:

Date of Retirement:

CONTACT NO.:

Address:

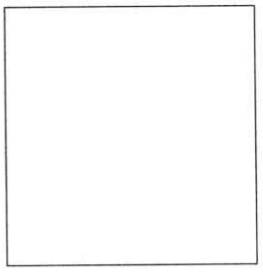
Photo of the Employee

Health Card No.

ENTITILEMENT:

Signature of Director

DEPENDENTS OF THE PENSIONER

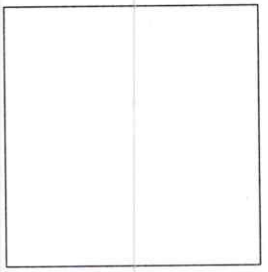


Name:

RELETIONSHIP:

D.O.B.:

AADHAAR NO.:XXXX XXXX .....

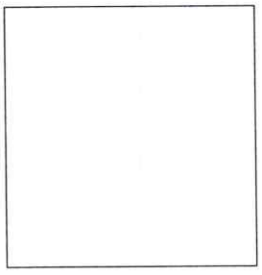


Name:

RELETIONSHIP:

D.O.B.:

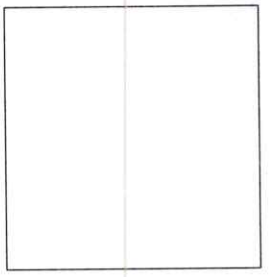
AADHAAR NO.:XXXX XXXX .....



RELETIONSHIP:

D.O.B.:

AADHAAR NO.:XXXX XXXX .....



RELETIONSHIP:

D.O.B.:

AADHAAR NO.:XXXX XXXX .....

THIS CARD IS VALID ONLY WHEN PRODUCED ALONG WITH AADHAAR CARD OR ANY VALID GOVT. ID.

Signature of Director

INSTRUCTIONS :-

This Card may be surrendered on death of the Pensioner to the issuing Authority. If lost, the loss should be reported immediately to the Head of Office, ICAR-CIFA, Bhubaneswar, Odisha as well as nearest Police Station.

Loss Penalty is ₹200/- (Rupees Two Hundred only)

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