भाकृअनुप - राष्ट्रीय व्यावसायिक कृषि अनुसंधान संस्थान - राजमुंद्री
ICAR-NATIONAL INSTITUTE FOR RESEARCH ON COMMERCIAL AGRICUTURE: RAJAHMUNDRY

No.F.53(2)/2026-27/Adm.II(MB) Date: 16-10-2026

परिपत्र / CIRCULAR

Sub: Submission of Application Form and Photographs for Issuance of Employee Medical Card – Reg.

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It is hereby informed that new Employee Medical Identification Cards are being prepared and issued. These cards will serve as official proof of entitlement for availing medical benefits as per Rules.

To facilitate the timely processing and printing of these cards, all employees are strictly instructed to submit their completed application forms (enclosed) along with the required family details and documents according to the guidelines outlined below:

Application Proforma: Employees must neatly fill out the prescribed application form in block letters. Incomplete or illegible forms will not be accepted.

Passport Size Photographs: One (1) recent, high-quality passport-size color photograph of the employee and each eligible dependent family member must be attached to the form. Please write the Employee Name, Employee ID, and Relationship clearly on the reverse side of each photograph to avoid any mismatch during printing.

Identity Proof: A self-attested photocopy of the Aadhaar Card for the employee and each dependent must be attached as supporting evidence.

Joint Declaration: If the spouse is a Government employee, the Joint Declaration Form must be enclosed, duly signed by the concerned Officer of his/her parent department. This serves as proof of whether facilities like Medical/LTC/CEA etc., are being availed from the parent department or from this Institute. If not submitted, reimbursement of medical claims/LTC/CEA etc., will not be processed under any circumstances.

Only family members who are fully dependent on the employee and meet the criteria specified under the CS(MA) medical rules are eligible to be listed.

The duly filled-in application form, along with all photographs and enclosures, must be submitted **on or before 30-10-2026**.

This is issued with the approval of the Competent Authority.

कुलदीप
16/10/26

Encl: 1) Medical Card Proforma
2) Joint Declaration

(कुलदीप पाटीदार) / (KULDEEP PATIDAR)
प्रशासनिक अधिकारी / ADMINISTRATIVE OFFICER

प्रतिलिपि प्रेषित / Distribution to:

1) All the Heads of Divisions/Sections/Research Stations with a request to bring this to the notice of all the staff members working under their control.

2) In-charge, AKMU with a request to upload the same in our website

Nsn/*

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कर्मचारी मेडिकल कार्ड के लिए आवेदन पत्र

APPLICATION FORM FOR EMPLOYEE MEDICAL CARD

Employee Full Name (Block Letters)	
Designation	
Employee ID No. & e-HRMS ID No.	
Division / Section	
Date of Birth	
Date of Joining	
Blood Group	
Basic Pay & Pay Scale & Level	
Aadhaar Number	
Mobile Number & Email ID	
Permanent Residential Address	

Details of Dependent Family Members

S.No	Name of Beneficiary	Date of Birth	Gender	Relationship	Aadhaar Number
1					
2					
3					
4					

I hereby declare that the particulars given above are correct and true to the best of my knowledge and match my official service records. The family members listed above are wholly dependent on me as per the organization's medical rules.

Date: _____

Place:_____

कर्मचारी के हस्ताक्षर
Signature of the Employee

FOR OFFICE USE ONLY:

Card Serial No: _____

Date of Issue: _____

Validity Period: _____

नियंत्रण अधिकारी के हस्ताक्षर
Signature of the Controlling Officer

Form No. A4

JOINT DECLARATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES/ LEAVE TRAVEL CONCESSION/ CHILDREN EDUCATION ALLLOWANCE (IN CASE BOTH ARE 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 such as Medical Facilities, Leave Travel Concession, Children Education Allowance etc. from my office/from the office of my wife for myself and my family members as mentioned below:-

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

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 such as Medical Facilities, Leave Travel Concession, Children Education Allowance etc. from my office/from the office of my wife for myself and my family members as mentioned below:-

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

Signature of Employee: _____

Designation: _____

Date: _____

Note:

1. Acceptance of the declaration by the Competent Authority in the spouse's office should be submitted alongwith this Declaration failing which it would not be accepted.
2. In case of any change in future, the same should also be intimated jointly.