

**Mukh Mantri Punjab Cancer Raahat Kosh Society
Recommendation by District Level Committee**

District -----

Name of the Patient	Age/ Sex	Father's/ Husband's Name	Complete Residential address with Contact number	Whether belonging to Reserved Category (SC/ST only) Attach the proof	Name / address of the Hospital where the treatment is going on currently	Diary No and date on Patient Application by CS Office	If grant was availed earlier under this scheme, Sanction Letter Number & Date Attach the proof	Estimate /Invoice given by Hospital attached	CGHS (Non- NABH) lowest Rates	Amount Recommended by District level Committee	Date of Recomm endation
1	2	3	4	5	6	7	8	9	10	11	12
						Diary No..... Date.....		Amount..... Dispatch No..... Date.....			

For the treatment of above mentioned patient, the District Level Committee recommends an amount of Rs.(in Words Rupees.....) from Mukh Manti Punjab Cancer Rahhat Kosh Scheme to be paid to the Hospital

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|------------------------|------------|-----------------|
| 1. Medical Specialist | Name | Signature..... |
| 2. Surgical Specialist | Name | Signature..... |
| 3. Gynecologist | Name | Signature..... |
| 4. Civil Surgeon | Name | Signature.....* |
| 5. Deputy Commissioner | Name | Signature.....* |

(*with Seal)