DECLARATION FORM

(For Leave Travel Concession and Medical Facility)

I……………………………………………………………………………………… hereby declare that the following are members of my family who are wholly dependent on me.

DETAILS OF FAMILY

(i) Husband, Wife, Children, Step Children

SLNo.	Full Name	Relationship	Date of Birth

(ii) Father, Mother/Minor Brothers/Sisters/Widowed Daughters/Widowed Sisters, residing with me

SLNo.	Full Name	Relationship	Age in case of minor brothers/ sisters/children and date of birth) **Date of birth**	Status Married/ Unmarried/ Widowed
			/ /	
			/ /	
			/ /	
			/ /	

UNDERTAKING

I undertake that –

1. The children/step children claimed to be dependent do not have income exceeding Rs.3500/- per person just month from all sources including stipend and scholarship.

2. The income of parents from all sources including pension (inclusive of temporary increase in pension and pension equivalent of DCRG benefits) does not exceed Rs.3500 / -per month. (If anyone mother/father has the said income, both of them will come under dependents category.)

3. My father is not alive/ my father is wholly dependent on me and income of my widowed sisters/unmarried sisters does not exceed Rs.3500/-per month. From all sources. For each person.

4. In the event of any change in the status of any of the above mentioned persons, which effects the eligibility, I shall inform the Health Centre and DOFA Office immediately about the same.

5. The particulars of dependent members of my family as given are correct. If any statement is found to be untrue I shall be liable for disciplinary action.

Date:

Signature: ………………………......
Name: . ……………………….........
Designation:..……………………....
Department:…...……………………
P.F.No.:….…………………………....

FORWARDED

(Head of the Department)

Note: Children getting stipend or scholarship exceeding Rs.3500/- per month will not be entitled for LTC but they will he eligible for Medical Facilities.