Annexure-3

DECLARATION FOR SEEKING TRANSFER BENEFIT UNDER MEDICAL GROUND (MDG)

I, Sh./Smt……..(name of the employee), ……. (post), solemnly declare the following details to take transfer benefit under medical ground (MDG ground):

S.N.	Particular	Details to furnish
1	Name of the patient	
2	Relation of the patient with the employee	**Self/ Spouse/ Son/ Daughter** (strike out whichever is not applicable)
3	(i) Medical Certificate No.	
	(ii) Date of Issue of Certificate	
	(iii) Hospital name with full address	
	(iv) Name of the Medical Officer who has issued the certificate	Name: Address:
	(v) Designation/Rank of the Medical Officer	
4	Disease Code as per Annexure 1 of KVS Transfer Policy	
5	Brief description of Disease as per Annexure 1 of KVS Transfer Policy	

The medical certificate issued by the Medical Officer as stated above is enclosed also.

Signature of the employee

Date: ……

Verified by ASO/SSA/JSA/Any employee delegated by the Controlling Authority
Signature:
Name:
Designation:

Countersigned by the Controlling Officer with stamp

Name:

Designation:

MEDICAL CERTIFICATE

(TO AVOID DISQUALIFICATION, PLEASE DO NOT USE ABBREVIATION, FILL IN CAPITAL LETTERS ONLY. PLEASE DO NOT ATTACH ANY ENCLOSURE EXCEPT WHERE SPECIFICALLY ASKED FOR)

Name of Patient: _____

Relation of the patient with the employee: _____
(Self/spouse/dependent son/dependent daughter)

Address of the Doctor
_____
_____
_____
Contact No. _____(Land Line)
_____(Mobile)
Date: _____

Certificate

I, Dr. _____ with Medical Council Registration No._____hereby certify that Shri/Smt./Ms./Miss/Master_____ aged _____Gender_____*who himself/herself is a KVS employee or *dependent son/ dependent daughter/wife/husband of Sh./Smt./Ms. _____ (Name of KVS employee) is suffering from the disease/diseases with the details as follows and that treatment of this disease is not at all available at this station or in its vicinity (*Strike off whichever is not applicable).

1) IN CASE OF CANCER

1. Type of cancer with site affected:
2. Date when it was detected first:
3. Brief history-Pathological report with reference No. & dates:
   _____
   _____
4. T.N.M. classification (if applicable):
5. Evidences in support of uncontrolled growth
6. Evidences in support Metastasis:
7. Condition of neighboring or surrounding structures:
8. Treatment being continued (in brief):
9. Full name of surgery/surgeries in connection with dates:

2) IN CASE OF PARALYTIC STROKE

1. How many extremities are affected?
2. Grading of muscle power at present:
3. Grading of muscle power at the onset of disease:
4. Duration of loss of muscle power:
5. Any recovery after the onset till date:
6. Most Direct cause of loss of Muscle Power:

3) IN CASE OF RENAL FAILURE

1. Name of disease-causing Renal failure:
2. Evidences in support of Chronic Irreversible changes:
3. Number of Dialysis done with dates:
4. Kidneys involved (single/both):
5. Any surgery including renal transplantation done (Yes/No):

4) IN CASE OF CORONARY ARTERY DISEASE

1. Name of the surgical procedure undergone. CABG/Angioplasy:
2. Date of surgical procedure:
3. Name of Doctor-Surgeon:
4. Name of Hospital:

5) IN CASE OF THALASSEMIA

1. Name of disease (with specification- major or minor):
2. Date of first detection:
3. Whether blood transfusion required? (Yes/No):
4. If so, periodicity of duration of blood transfusion/replacement required by the patient/chelation therapy:
5. Blood transfusion done last:_____(DD/MM/YYYY)

6) IN CASE OF PARKINSON'S DISEASE

1. Date of detection of disease:
2. Duration of treatment undergone:
3. Date & designation of treating Neurologist:
4. Whether admitted in hospital & if so, details thereof:
5. Progressiveness of the disease- please specify:
   (To be certified by a neurologist)

7) IN CASE OF MOTOR - NEURON DISEASE

1. Date of detection of the disease:
2. Duration of treatment undergone:
3. Name & designation of the treating neurologist :
4. Result of EMG test report & MRI:
5. Grading of muscle power at present:

8) Any other disease with more than 50% mental disability duly examined by and recommended by the Regional Medical Board with latest records/reports (within last three months):

_____

_____

9) AIDS
   1. Date of detection of the disease:
   2. Duration of treatment undergone:

(The Doctor is requested to "Cross" 1/2/3/4/5/6/7/8/9 above whichever is not applicable in the case of the Patient)

Place : _____

Date : _____

(Signature of the Civil Surgeon)
Name _____
Name of the Deptt. _____
Name of the Hospital _____

Seal:

Signature and name of the
KVS employee (applicant) : _____

Signature and Name of the Patient: _____

(If the certifying doctor is below the rank of Civil Surgeon or equivalent the certificate should be countersigned by a doctor of the rank of Civil Surgeon or equivalent)