



भारतीय प्रौद्योगिकी संस्थान गुवाहाटी  
INDIAN INSTITUTE OF TECHNOLOGY GUWAHATI

FORM - 2

DECLARATION BY THE EMPLOYEE

(For details of nomenclatures, definitions etc. please see Intranet > Section > Administration > Rules)

Name of the employee..... Emp.No.  
.....

Designation..... Dept. / Section / Centre .....

(A) REGARDING MARRIAGE

[ Delete which is not applicable ]

I, Dr. / Mr. / Ms. .... declare as under:

- I. That I am unmarried / a widower / widow.
- II. That I am married and have only one spouse living / my spouse has no other living spouse.
- III. That I am married and have more than one spouse living / contracted another marriage during the life-time of my spouse / contracted a marriage with a person who has already one or more spouse(s) living. Application for grant of exemption is enclosed.

Date : \_\_\_\_\_

Signature of the employee

FORM OF APPLICATION FOR GRANT OF EXEMPTION (Vide para (iii) of the above declaration)

To  
The Director  
Indian Institute of Technology Guwahati

Sir,

I request that in view of the reasons stated below, I may be granted exemption from the operation of restriction on the recruitment to service of a person having more than one spouse living / having contracted another marriage during the life-time of the spouse / having contracted a marriage with a person already having one or more spouse(s) living.

Reasons : .....  
.....

Date : \_\_\_\_\_

Signature of the employee

(B) REGARDING HOME TOWN

(must be furnished within 6 months from the date of joining)

I, Dr. / Mr. / Ms.....do hereby declare that my Home Town for the purpose of Leave Travel Concession is ..... in the District of ..... State ..... Nearest Railway Station & Air Port are ..... and ..... respectively.

The reason for declaration of ..... as my Home Town is / are .....  
.....  
.....

Date : \_\_\_\_\_

Signature of the employee

**(C) REGARDING PARTICULARS OF FAMILY MEMBERS FOR LTC / MEDICAL CLAIMS**

I, Dr. / Mr. / Ms ..... do hereby declare that I have the following family member(s), who are wholly dependent on me for the purpose of Leave Travel Concession / Medical claims.

Sl. No.	Name(s)	Relation-ship	Whether residing with or not	Whether Married / Unmarried / Widow	Date of Birth / Age	Whether employed, pensioner, businessman or others	Monthly income from all sources

Date : \_\_\_\_\_

\_\_\_\_\_  
Signature of the employee

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I solemnly affirm that all above declarations are true and I understand that in the event of any of the above declarations being found to be incorrect, I shall be liable to disciplinary action including dismissal from service. Further I undertake to update the all / any of the above declarations as and when it will be so required.

Date : \_\_\_\_\_

\_\_\_\_\_  
Signature of the employee

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**ADMN. NOTE:**