Annexure -1

UNDERTAKING TO BE SUBMITTED BY AAI BENEFICIARY AT THE TIME OF SUBMITTING CHRONIC CERTIFICATE

Name of AAI employee (Serving or Retired): _____

Employee no: _____

Name of the Patient: _____

Relationship with Patient: _____

Address of the Patient: _____

Declaration

1. I hereby declare that the above given information is best to my knowledge and is as per rules mentioned in AAI Medical Policy. I will be held responsible in case of any false information.
2. The medicines recommended by Doctor in the Chronic certificate is being consumed by the patient.

Date: _____

Place: _____

Signature: _____

Name of the employee _____

Employee number: _____

Enclosure:

1. Chronic disease certificate certified by Doctor.
2. Prescription dated _____ of Dr. _____
3. Medical receipt no Medical report no _____ dated _____

Annexure -1

Airports Authority of India

Department OF Human Resource

Chronic Certificate

This is to certify that Sh / Smt _____ (Name of patient) aged _____ Years (Relationship) of Sh / Smt _____, who is working/ has worked (in case of retired employee) as _____ (Designation) in Airports Authority of India is suffering from _____ disease which is Chronic disease mention at serial no _____ of Annexure _____ of AAI Medical Policy and is under treatment of Doctor (Specialist/MD/MS/Hospital) _____ Registration no _____ Since _____.

Medicine/Drugs/Test to be included under Chronic Diseases are

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
10. _____ 11. _____ 12. _____

The above mentioned prescribed medicine are subject to review of patient condition.

Signature of the doctor: _____

Name of the Doctor: _____

Rubber seal with Regn no: _____