कार्यालय महानिदेशक लेखापरीक्षा (गृह, शिक्षा एवं कौशल विकास)

Office of the Director General of Audit

(Home, Education and Skill Development)

इन्द्रप्रस्थ एस्टेट, नई दिल्ली-110 002

Indraprastha Estate, New Delhi-110 002

प्रशासन II

संख्या: प्रशा.II/6-5/प्रा.चि.परि.नि./2020-21/2900-2955 दिनांक: 11.03.2021

विषय: प्राधिकृत चिकित्सा परिचरों (Authorised Medical Attendants) का कार्यकाल पुनः एक वर्ष की अवधि के लिए बढ़ाने तथा नए प्राधिकृत चिकित्सा परिचर की नियुक्ति के संबंध में|

वर्ष 2020-21 के लिए नियुक्त किए सभी प्राधिकृत चिकित्सा परिचरों (Authorised Medical Attendants) के कार्यकाल की अवधि दिनांक 31.03.2021 को समाप्त हो रही है| इस संबंध में इस कार्यालय के कैडर नियंत्रण के अधीन आने वाले सभी अधिकारियों/कर्मचारियों, जो सी.जी.एच.एस. की सुविधा प्राप्त नहीं कर रहे हैं तथा उनका क्षेत्र CGHS covered area में नहीं आता हैं, से अनुरोध है कि वह अपने क्षेत्र के लिए पहले से नियुक्त प्राधिकृत चिकित्सा परिचर का कार्यकाल वर्ष 2021-22 के लिए बढ़ाने हेतु अपने आवेदन प्राधिकृत चिकित्सा परिचर की सहमति व उनकी Undertaking सहित दिनांक 19.03.2021 तक प्रशासन II अनुभाग में अवश्य भिजवा दें| यदि कोई अधिकारी/कर्मचारी अपने क्षेत्र के लिए नए प्राधिकृत चिकित्सा परिचर की नियुक्ति के लिए आवेदन करना चाहता है तो उसे अपने आवेदन पत्र के साथ निर्धारित प्रपत्र में डॉक्टर का Verification Form (Annexure "C") उसका Declaration और Undertaking प्रस्तुत करने होंगे| नए AMA की नियुक्ति डॉक्टर की Police Verification एवं अन्य औपचारिकताएं पूरी करने के उपरांत ही की जाएगी|

संलग्नक: यथोवर्णित

11/3/21

व. लेखापरीक्षा अधिकारी (प्रशासन)

डाक सूची के अनुसार

To

The Director (Admn)
O/o the Director General of Audit (CE),
I.P. Estate, New Delhi-110002.

Sub: Extension of period of AMA from .... to 31-03-2022

With reference to your office letter No.Admn.II/6-5/AMA Appointment/2020-21/...............................dated ....03.2021 on the subject cite above, I am willing to continue as Authorised Medical Practitioner (AMA) for the next financial year i.e. 2021-22 for the employees of your office and members of their families residing in the circle of 16 kilometre of .... In this regard, I will abide by the provisions of CS (MA) Rules, 1944 and circulars/orders/amendments/rates issued/notified by the Govt./Health Departments etc from time to time.

Place:

Date:

Signature of the Registered
Medical Practitioner with Seal

UNDERTAKING

I,..S/o...resident of
....
Taluka.................................District.................................do hereby solemnly declare and affirm that I am not involved in any corrupt practice and no case has been lodged against me at any local police station/CBI/CVC/any court etc.

Place:

Date:

Signature of the Registered
Medical Practitioner with Seal

ANNEXURE "C"

(to be filled by the concerned doctor in duplicates)

VERIFICATION FORM FOR APPOINTMENT OF AUTHORISED MEDICAL ATTENDANT IN THE AREAS NOT COVERED BY CGHS

Warning:

The furnishing of false information or suppression of any factual information in the verification form would be a disqualification for appointment as AMA. If the fact that the false information has been furnished or that there has been suppression of any factual information in the verification form comes to notice at any time during the period of appointment of AMA, his services would be liable to be terminated.

Photograph of the candidate.

1.	Name in full (Block letters) (The name should be same as in his qualification degree).	
2.	Father/Husband's Name	
3.	Date of Birth	
4.	Nationality	
5.	Medical Qualification i.e. MBBS/MD (Photocopy of the certificate/marksheets should be annexed).	
6.	MCI registration number and place of registration (Photocopy of the certificate/mark sheets should be annexed).	
7.	Name of Medical College and the University from where medical degree (Bachelor) obtained.	
8.	Name of Medical College and the University from where medical degree (Master, if any) obtained.	
9.	Full Address of Clinic/Medical centre (i.e. Number, Lane/ Street/ Road Village, Thana, Post Office, District etc.)	
10.	Present Residential Address in full (including the name of Thana)	
11.	Permanent Residential Address in full (including the name of Thana)	
12.	Work experience, if any in Government Hospital.	

13.	Work experience, total (in brief):	
14.	Have you ever been arrested, prosecuted, or fined by a Court of Law. If yes, give full details.	Yes/No.

I certify that the foregoing information is correct and complete to the best of my knowledge and belief.

Date:
Place:

Signature of candidate
(With stamp)

(To be filled by Verifying Authority i.e. local police Department)

Certified that the verification in respect of Dr...
Resident of ....
....
Whose clinic is situated at ....
....
....
has been carried out and nothing adverse has been noticed against him/her in our records.

Date:
Place:

Signature
Name & Stamp of verifying authority.