

SRI LANKA POLICE INSPECTORS' ASSOCIATION
D.S.FONSEKA ROAD, COLOMBO-05
TELEPHONE /FAX 2 5 5 6 6 2 9

The Hony. Secretary/SLPIA

**APPLICATION FOR MEDICAL ASSISTANCE FEES FOR
TREATMENT ABROAD OR BY-PASS OPERATIONS IN SRI LANKA**

01. Full Name:-.....
.....
02. Date of Birth:-.....
03. Present Address:-.....
.....
04. Telephone No.:-.....
05. NIC No.:-.....
06. Date joined the service & rank:-.....
07. Date promoted to the rank of Sub-Inspector of Police.....
08. If absorbed to the Regular Service, the date of absorption & the rank:-.....
09. Present rank & Station:-.....
10. Bank Account No.:-.....
11. Details of Sickness /Injury/Ailment:-.....
.....

Medical Treatment Abroad

12. Nature of Operation / Treatment
13. Name of the Hospital and Country
14. Date intend to receive treatment
15. Name of the Physician and Mailing Address

By – Pass Operation in the Island

16. Nature of the Surgical operation
17. Name of Hospital and Doctor
18. Date intend to under go the By-pass Operation
19. The following documents should be attached:

a. A certificate from a qualified Physician to the effect that the patient cannot be treated in Sri Lanka or re the need to under go a by-pass operation locally.

- b. A certificate to the effect that the patient is going abroad precisely only for medical treatment abroad, but not for any other purpose, signed by the Division in Charge.
- c. The Name of the location of the Medical Institution that the patient intends to seek medical treatment abroad or local be indicated with the details of the Doctor/Surgeon and a certificate from Doctor re the intended medical treatment, including dates / times etc...
- d. The bond of the Association should be attached.

I hereby declare that I am a Member of the Sri Lanka Police Inspectors' Association, presently serving in (Name of the Station). I have received injuries / suffered from sickness as described above, and needs such medical treatment. I have no earlier claimed for Medical Fees from the Association. I assure to act in accordance with the rules and regulations of the Association in regard to this payment. The necessary original documents are enclosed herewith. It is appreciated, if the cheque is drawn on the above Bank Account early please.

Date

Signature of Applicant

FOR OFFICE USE ONLY

Hony. Secretary / SLPIA

The applicant is a member of the SLPIA, holding the membership number I have checked with the records and found that he / she has not earlier claimed Medical Assistance fees. The documents were checked and found correct and in order. The payment is recommended please. The payment is not recommended due to following reasons;

- a.
- b.
- c.

Date

Administrative Officer/SLPIA

Administrative Officer/S.L.P.I.A

The payment of Rs.....was approved by the Executive Committee during the meeting conducted on Please draw the cheque on A/C& update the registers & the computer, & file the papers.

Voucher No:-.....

Cheque No:-.....

Date:-.....

Hony. Secretary/SLPIA

Specimen of the Bond

I (Full Name and the Rank of the applicant) attached to (Station) in the District of (Name of the District) for the payment of a grant under the scheme of Medical Assistance fees for treatment Abroad or by-pass operation in Sri Lanka for myself / my spouse / my child (Name of child) aged (delete what is inapplicable) (age of child) (Full Name and he Rank of the Applicant) undertake to refund the grant of Rs..... (Amount of the grant) in full, if myself / my spouse / my child had not left the Island for Medical treatment abroad or not undergone the by-pass operation in Sri Lanka. (delete what is inapplicable.)

.....
(Signature of the Applicant of a Rs.20/= stamp)

Date:-

- 01. Full Name of the Applicant
- 02. Post with Rank
- 03. Station or Branch
- 04. National Identity Card No
- 05. Date

Witnesses

- 01. Full Name
- Post with Rank
- Station or Branch
- National Identity Card No
- Date Signature

- 02. Full Name
- Post with Rank
- Station or Branch
- National Identity Card No
- Date Signature