FAMILY DECLARATION FORM
CONTRIBUTORY MEDICAL SCHEME (CMS)
IIEST, Shibpur

FOR INSTITUTE CONTRACTUAL EMPLOYEES

1. Name :_____

2. Designation :_____ 3. Department:_____

4. Contract Tenure :_____ to_____

5. Service Renewed Since :_____6.Gross Salary : _____

7. Employee Code : _____ 8. Blood Group:_____

9. Date of Birth :_____10. Contact No.:_____

11. Residential Address :_____

_____

_____

12. Email :_____

13. Dependant's Declaration:

Sl. No.	Name/s	Relationship with Contractual Employee	Date of Birth	Blood Group	Remarks, if any
a.					
b.					
c.					
d.					
e.					
f.					

Contd.P/2

14. Declaration :

- I do hereby undertake to intimate the authority immediately, in case of any change in my family members declared as dependant in this Family Declaration Form. If I fail to intimate and / or if any manipulation is found in my declaration, the authority may initiate action against me.

- I do hereby undertake to surrender the CMS Health Record Books at the time of my leaving the Office on termination/ resignation/ non renewal / any decision taken by the authority.

- I do hereby declare that the information furnished by me in this application are true to the best of my knowledge and belief. No information has been concealed or has been misrepresented.

Date:

_____

Signature of the Contractual Employee

Enclo: (Please use √ mark where applicable)

- Proof of residence / stay of dependants
- Proof of age of son /dependant brother
- Disability certificate, if age of son is above 25 years
- Copy of blood group report.