# PHA FOUNDATION

**MINISTRY OF HOUSING & WORKS**

Government of Pakistan

* * * * * * * * * *

## APPLICATION FORM FOR THE PROVISION OF MEDICAL FACILITIES

I Mr/Ms/Mrs: ______________________________________________________________

Designation: ____________________________________BPS: ___________________________

Furnish information in respect of my family members etc for the purpose of medical treatment, keeping in view of the following conditions:

a) Employee As defined in PHA Foundation Regulations for Medical Attendance,2017.

b) Family Means spouse (viz, dependent husband or wives) dependent parents, and legitimate unmarried children and unmarried stepchildren, residing with and wholly dependent upon the employee/s.

Explanation – 1 Spouse of an employee shall be deemed to be dependent upon him/her so long as he/she is not judicially separated.

Explanation – 2 Parents of an employee shall be deemed to be wholly dependent on the employee. If not serving or retired or drawing pension.

Explanation – 3 Unmarried sons and stepsons shall be deemed to be wholly dependent upon her/him till they reach the age of 18 years.

Explanation – 4 Daughters and stepdaughters of an employee shall be deemed to be wholly dependent on her/him till they are married.

Explanation – 5 Mentally or physically handicapped and completely dependent family members declared as such shall be considered wholly dependent on employee, notwithstanding the age limitation given above.

### PARTICULARS OF FAMILY

| Sr. No. | NAME OF FAMILY MEMBERS | DOB | AGE | CNIC/ B. FORM | RELATIONSHIP | THUMB IMPRESSION |
|---|---|---|---|---|---|---|
| 01 | | | | | | |
| 02 | | | | | | |
| 03 | | | | | | |
| 04 | | | | | | |
| 05 | | | | | | |
| 06 | | | | | | |
| 07 | | | | | | |

PHA FOUNDATION

| 08 | | | | | | |
|---|---|---|---|---|---|---|
| 09 | | | | | | |
| 10 | | | | | | |

My residential address is ____________________________________________________________________

______________________________________________________________________________________

I solemnly declare and affirm that the information given above is correct to the best of my Knowledge and belief. I understood that in case of any information contained herein found incorrect or false at any stage, I shall be liable to legal action as per rules. Any mis-statement, mis-representation of fact, impersonation, altering the prescription or tempering with the vouchers, fake claims shall be treated as **MISCONDUCT** and will be grounds for cancelation of medical facility.

**Name:** ________________________________ **Designation**:____________________________

**Date:** ____________ **Thumb Impression:** ______________________

**Note:** Attach two recent passport size color photographs of self and all dependents for issuance of PHA-F Health Identity card. Mention full name of dependent along with employee on the back side of photograph. Also attach copy of official card, CNICs self & Dependents along with B-Form/Birth Certificate of children below 18 years.

**CERTIFICATE OF AUTHENTICATION FROM THE HEAD OF DEPARTMENT/DIRECTOR OF THE WING (FOR IN-SERVICE EMPLOYEE)**

It is certified that ________________________ is working as ______________________ in the Directorate/Wing_____________________________________ and particulars shown above to avail the medical facilities are correct to the best of my knowledge.

**Signature of the Head of Deptt./**
**Director of the Wing & Stamp**



PHA FOUNDATION