All India Institute of Medical Sciences, Mangalagiri
అఖిల భారత వైద్య విజ్ఞాన సంస్థ, మంగళగిరి
अखिल भारतीय आयुर्विज्ञान संस्थान, मंगलगिरि
A Central Autonomous Body under PMSSY, MoH&FW.

UNDERTAKING

I hereby undertake that my father / Mother / Brother / Sister / Son / Daughter or……. namely (Patient Name) …… CR No……

Age / Sex …… is under treatment in your ward / Bed No……. under……. Department.

- ☐ We have no source of income and presently we are **having / not having** BPL Card / Dr. NTRVST card.
- ☐ None of my family member (in Blood Relation) is in **Government Service / ESI covered** / not entitled for medical reimbursement from any other source.
- ☐ We will not submit any medical bills / invoice for verification from AIIMS Mangalagiri.
- ☐ We are unable to bear the treatment expenses in your hospital and our annual income is
  - ☐ < 1 lakh ☐ 1- 2 lakh ☐ > 2 Lakh
- ☐ Kindly provide us free / concession of treatment charges.

The above said information is best of my knowledge.

Signature of Patient / Relative …….

Full Name …….

Relation with Patient …….

Date …….

Full Address …….

Mobile No. ……..

To be filled by Treating Doctor

Diagnosis: Ward / Bed No:

Treatment Required:

Total Cost:

Treating Doctor Sign & Stamp **HoD Sign & Stamp**

Remarks of MSSO (Medical Social Service Officer) with Signature

Attachment Copies of ☐ Aadhar Card ☐ BPL Card ☐ Dr. NTRVST Card ☐ Income Certificate

☐ Others……

Hospital charges may be exempted up to Rs…… of Total Rs ……

Comment:

Signature

Approved / Not approved **Countersigned by MS / DMS**

Comment if any: