DECLARATION FORM
(For leave Travel Concession and Medical Facility)

I .... hereby declare that the following are members of my family who are wholly dependent on me.

DETAILS OF FAMILY

(i) Husband. Wife, Children, Step Children

S.No	Full Name	Relationship	Date of birth

(ii) Father, Mother/Minor Brother/Sisters/Widowed Daughter/Widowed Sisters, residing with me

S.No	Full Name	Relationship	Age in case of minor brother/sisters/ children	Status Married /Unmarried/Widowed

UNDERTAKING

I undertake that –

1.The children/step children claimed to be dependent do not have income exceeding Rs 3500/- per person just month from all sources including stipend and scholarship.

2.The income of parents from all sources including person (inclusive of temporary increase in pension and pension equivalent of DCRG benefits) does not exceed Rs 3500/-per month. (If anyone mother/father has the said income, both of them will come under dependent category) .

3.May father is not alive/my mother is wholly dependent on me and income of my widowed sister/ unmarried sister does not exceed Rs 3500/- per month. Form all sources. For each person.

4.In the event of any charge in the status of any of the above mentioned persons, which effects the eligibility, I shall inform the Directorate Office immediately about the same.

5.The particular of dependent members of my family as given are correct. If any statement is found to be untrue I shall be liable for disciplinary action.

Date:

Name :
Signature :
Designation :
Department :
P.F. No :

FORWARDED
Approved
(Registrar)

Note: Children getting stipend or scholarship exceeding Rs 3500/- per month will not be entitled for LTC but they will be eligible for Medical Facility.