

**NATIONAL INSTITUTE OF TECHNOLOGY SILCHAR**

**DECLARATION FORM**

(For Availing Medical Facilities)

I, \_\_\_\_\_, designation \_\_\_\_\_, department of \_\_\_\_\_ hereby declare that following are the members of my family who are wholly dependent upon me. Their income from all sources does not exceed Rs. 3500/- per month.

**DETAILS OF FAMILY MEMBERS (INCLUDING SELF):**

<b>SN</b>	<b>NAME IN FULL</b>	<b>DATE OF BIRTH</b>	<b>RELATIONSHIP</b>	<b>STAMP SIZE PHOTO</b>

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

\_\_\_\_\_  
(Signature of the employee)

Forwarded

(Head of Dept / Section)