**CENTRAL GOVERNMENT EMPLOYEES WELFARE COORDINATION COMMITTEE**
**OFFICE OF THE CHIEF COMMISSIONER OF CENTRAL EXCISE,**
**26/1, MAHATMA GANDHI ROAD, NUNGAMBAKKAM, CHENNAI-34.**
**TELEPHONE: 28335137, FAX:28331133 ,**
**Visit us at : www.chennaicentralexcise.gov.in**

CHAIRMAN: SMT.JANAKI ARUNKUMAR, IRS
CHIEF COMISSIONER OF CENTRAL EXCISE,
CHENNAI ZONE & CADRE CONTROLLING AUTHORITY,
TAMIL NADU & PUDUCHERRY.

SECRETARY: SHRI.A.V.T.BHARATHI DHASAN, IRS
DEPUTY COMMISSIONER, (CCA)

No. CGEWCC /2013-14. Dated. 30 .11.15

To
All Authorised Medical Attendants,
(as per mailing list)

Sir/Madam,

Sub: **Appointment of AMAs for the year 2016**-reg.

**********

The Central Government Employees Welfare Co-ordination Committee, Chennai has nominated you as one of the Authorized Medical Attendants for the year 2015. In this connection, it is requested that if you are interested in your nomination being extended for the year 2016, you may please send the undertaking in the prescribed proforma (Annexure-B) duly notarized and to be given on non-judicial stamped paper of the appropriate value and a proforma in Annexure C (proforma enclosed). In addition to that, all the AMAS are required to send an undertaking in their letter heads in the format as below:

**"I am not involved in any corrupt practice and no case has been lodged against me at any local police station/CBI/CVC/any court, etc."**

The proforma and the above undertaking may be sent **on or before 10.12.2015.** alongwith valid e-mail id/mobile number.

Yours faithfully,

Encl: As above.

A.V.T. Bharathidhasan
30/11/15

(A.V.T BHARATHIDHASAN)
SECRETARY/ CGEWCC

Superintendent of Central Excise, Computer section, Chennai-I Commissionerate with a request to publish the same in Official website, www.chennaicentralexcise.gov.in

ANNEXURE-B

(to be given on non-judicial stamped paper of the appropriate value)

DECLARATION

I, ----------S/o/D/o ----------

Residing at ----------taluk, ----------

District---------- Contact No: ----------

do hereby solemnly declare and affirm

(i) that I am registered with the State Medical Council of the State of-------- ---------- under the Medical Council Act/Indian Medicine Central Council Act/Homoeopathy Central Council Act and that my Registration No is----------.

(ii) that I have gone through the Central Services (Medical Attendance) Rules, 1944 and agree to abide by the conditions laid down therein. I also agree to abide by the orders issued in this connection from time to time.

(iii) that I shall charge consultation and injection fee at the prescribed rates as may be modified from time to time.

(iv) that I have noted that my nomination as Authorised Medical Attendanat does not confer any right to be confirmed as an Authorised Medical Attendant and that my nomination could be terminated at any time by the nominating authority without assigning any reasons or giving any notice.

Place:
Date:

Signature of Registered Medical Practitioner

Attested----------

## ANNEXURE-C

(to be filled by the concerned doctor in duplicate)

### VERIFICATION FORM FOR APPOINTMENT OF AUTHORISED MEDICAL ATTENDANT IN THA AREAS NOT COVERED BY CGHS

**WARNING**

The furnishing of false information of suppression of any factual information in the verification form would be a disqualification for appointment as AMA . If the fact that the false information has been furnished or that there has been suppression of any factual information in the verification form comes to notice at any time during the period of appointemt as AMA his service would be liable to be terminated..

**Affix Photo below**

| | | |
|---|---|---|
| 1 | Name in Full(BLOCK LETTERS)<br>The name should be same as in his qualification degree | |
| 2 | Father / Husbund's name | |
| 3 | Date of Birth | |
| 4 | Nationality | |
| 5 | Medical qualification ie.<br>MBBS/MD/MS (photo copy of the certificate / marksheets should be be annexed | |
| 6 | MCI Registration number and place of registration<br>(photo copy of the certificate / marksheets should be be annexed | |
| 7 | Name of the Medical College and the University<br>from where medical degree(Bachelor obtained) | |
| 8 | Name of the Medical College and the University from where medical degree(Master, if any obtained) | |
| 9 | Full Address of Clinic /Medical Centre (i.e. Number / Street /Road /Village, Thana, Post Office, District etc. | |
| 10 | Present Residential Address in Full including the name of Thana. | |

| | | |
|---|---|---|
| 11 | Permenant Residential Address in Full including the name of Thana. | |
| 12 | Work experience if any in Government Hospital, If yes give full details | |
| 13 | Work experience Total (in years) | |
| 14 | Have you ever been arrested, prosecuted or fined by a Court of Law, if yes, give full details. | |

I certfiy that the foregoing information is correct and complete to the best of my knowledge and belief.

Place :
Date:

Signature of Candidate
(With stamp)

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**(To be filled by verifying Authority i.e. local Police Department)**

Certified that the verification in respect of Dr..... Resident of .....
whose Clinic is situated at.....
has been carried out and nothing adverse has been noticed against him /her in our records.

Place :
Date:

**Name & Stamp of verifying authority**