MED-8

ESB I.R.O. 34 SCHEDULED DISEASES

EMPLOYEES' STATE INSURANCE CORPORATION

Stamp of Dispensary / Clinic

Insurance No. :

Name of Insured Person _____

Occupation : _____

Place of work (Factory/Estt.) : _____

Residential address : _____

1. History of case : _____

2. Previous illness : _____

3. Present diagnosis : _____

4. Specialist's report in details _____

_____

5. Opinion of the specialist whether patient should receive dispensary/domiciliary/hospital treatment : _____

6. The patient requires/does not require abstention from work _____

7. Date of next reference to specialist for check-up _____

Dated _____

Signature of IMO/IMP with rubber stamp