



**NATIONAL INSTITUTE OF SCIENCE EDUCATION AND RESEARCH,
BHUBANESWAR**

DECLARATION FORM
(For Leave Travel Concession and Medical Facility)

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

DETAILS OF FAMILY

i) Husband, Wife, Children, Step Children

Sl. No.	Full Name	Date of Birth	Relationship
1			
2			
3			
4			

ii) Father, Mother, Minor Brothers/Sisters/Widowed Daughters/Widow Sisters residing with me:

Sl. No.	Full Name	Relationship	Date of Birth and age in case of minor	Marital Status Married/Unmarried /Widowed
1				
2				
3				
4				

UNDERTAKING

I undertake that:

1. The children/step children claimed to be dependent do not have income exceeding Rs. 3500/- per person in a month from the all sources including stipend and scholarship.
2. The income of parents from all sources including pension (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 not come under dependents category).
3. My father is not alive/wholly dependent on me and income of my widowed sisters/unmarried sisters does not exceed Rs. 3500/- per month from all sources for each person.
4. In the event of any change in the status of any of the above mentioned persons, which affects the eligibility, I shall inform to the office concern immediately about the same.
5. The particulars of dependent members of my family as given are correct if any statement found to be untrue I shall be liable for disciplinary action.

Date: _____

Signature: _____

Name: _____

Designation: _____

P. F. No.: _____

ACCEPTED BY

Director / Registrar / Administrative Officer (Admin.)