MOTILAL NEHRU COLLEGE : BENITO JUAREZ MARG
SOUTH CAMPUS : NEW DELHI-110021

MLNC/BJM/2017/ 10.07.2017

NOTICE

This is for information to all members of WUS Health Centre that the college has received a letter from WUS Health Centre which is self explanatory. Therefore, all are requested to act accordingly.

Officiating Principal

Enclosures :- As above.

W.U.S. HEALTH CENTRE
UNIVERSITY OF DELHI
DELHI-110007

Ph.: 27666257
27667908, 27667725/1660

Moti Lal Nehru College Ref No. 613 Sign. Date 1/6/17

WUSHC/2017-18/ 504

Dated : 30/5/17

SAO/SO
Supervisor
02.06.17
AIC

The Principal
Moti Lal Nehru College
Benito Juarez Marg,
New Delhi-110021

Respected Sir/Madam,

1. W.U.S. Health Centre is in the process of renewal of Health Booklets. All the employees of University of Delhi and Colleges who are members of W.U.S. Health Centre are requested to kindly fill up the **fresh membership proforma** certified by the competent authority and also attach the **last salary slip** for verification of Health Centre Booklets.

2. Deduction of W.U.S. Health Centre beneficiaries on account of Health Centre Contribution should not be stopped until you have received communication from W.U.S. Health Centre or members submits No Dues Certificate from W.U.S. Health Centre.

3. If W.U.S. Health Centre beneficiary proceeds on Deputation/Extra Ordinary Leave the member will have to submit Health Centre Contribution regulary else she/he will have to withdraw/terminate the membership.

4. If the Grade Pay of W.U.S. Health Centre beneficiary increases then Health Centre Contribution commensurating to the Grade Pay must be deducted and remitted to W.U.S. Health Centre.

Grade Pay	In Service
	Per Month Health Centre Contribution
Upto Rs. 1,630/- per month	Rs. 50/-
Rs. 1,800/-; Rs. 1,900/-; Rs. 2,000/- Rs. 2,400/- , and Rs. 2,800/- per month	Rs. 125/-
Rs. 4,200/- per month	Rs. 225/-
Rs. 4,600/-; Rs. 4,800/-; Rs. 5,400/-; and Rs. 6,600/- per month	Rs. 325/-
Rs. 7,600/- and above per month	Rs. 500/-

This may be brought to the notice of all the members working under your command and control.

Thanking you,

Yours faithfully,

Chief Medical Officer

D.U.P.-279-07-2013-50Pads

FORM NO. 4

W.U.S. HEALTH CENTRE
UNIVERSITY OF DELHI
SOUTH CAMPUS

MEMBERSHIP FORM FOR REGULAR EMPLOYEES

TOKEN CARD No. .....
Date .....

The Sr. Medical Officer I/c
WUS Health Centre,
University of Delhi, South Campus,
Benito Juarez Road,
NEW DELHI-110021
Tel. 24110505

Sir,

I .....wish to avail of the medical facilities provided at the WUS Health Centre, South Campus. I agree to abide by the rules and regulations as framed by the University of Delhi and also agree to have the necessary contribution deducted from my salary every month.

Yours faithfully,

Dated.....

(APPLICANT)

(TO BE FILLED IN BY THE APPLICANT)

NAME (IN BLOCK LETTERS) .....AGE..... SEX.....
DESIGNATION..... DEPARTMENT.....
RESIDENTIAL ADDRESS.....
.....TEL. No. .....

DETAILS ABOUT THE BENEFICIARIES-(SELF & DEPENDANTS ONLY):

S.No.	NAME OF THE BENEFICIARY	AGE	SEX	RELATIONSHIP	INCOME/ORGANISATION

(TO BE FILLED IN BY THE OFFICE OF APPLICANT)

Present Basic Pay Rs. ..... Grade Pay Rs. ..... Total Rs. ..... D/o. Increment.....

I hereby certify that the information filled in by the applicant and the office are correct to the best of my knowledge. He may please be made a member of the contributory health scheme of the WUS Health Centre, University of Delhi, South Campus. The health center contribution will be deducted as per rules from the salary of the applicant every month and the cheque drawn in favour of the Director, South Campus will be sent to the WUS Health Centre, South Campus. Incase he wishes to discontinue the membership, the same will be communicated to the health center.

Date.....

HEAD OF THE INSTITUTION

D.U.P.-281-07-2013-50Pads

W.U.S. HEALTH CENTRE, UNIVERSITY OF DELHI, SOUTH CAMPUS

ISSUE OF HEALTH BOOK - REGULAR EMPLOYEES

TOKEN CARD No. .....
DATE .....

The Sr. Medical Officer I/c,
WUS Health Centre,
University of Delhi, South Campus,
NEW DELHI-110021

Sir,

I am a Member of the WUS Health Centre, South Campus with Token Card No. ..... I wish to avail the facility of Health Book. I am enclosing herewith two photograph of each beneficiary for the purpose.

Yours faithfully,

NAME (IN BLOCK LETTERS) .....AGE..... SEX.....
DESIGNATION(WHEN LAST EMPLOYED).....D.O.A.....
DEPARTMENT.....
RESIDENTIAL ADDRESS.....
.....
..... TEL.....

DETAILS ABOUT THE BENEFICIARIES-(SELF & DEPENDANTS ONLY):

S.No.	NAME OF THE BENEFICIARY	AGE	DOB	SEX	RELATIONSHIP	INCOME
	.....					
	.....					
	.....					
	.....					
	.....					

*DOA - Date of Appointment, DOB - Date of Birth

PHOTOGRAPHS OF THE BENEFICIARIES
(If more than five beneficiaries please give details on reverse)
RELATIONSHIP & NAME

..... Self.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

Health Books S.No.. .....

Total No. of Books..... for all the beneficiaries received.

Date .....

Signature of Applicant

Dealing Asst.

Medical Officer I/c

DETAILS ABOUT THE BENEFICIARIES - (SELF & DEPENDANTS ONLY) :

S. No.	NAME OF THE BENEFICIARY	AGE	DOB	SEX	RELATIONSHIP	INCOME

PHOTOGRAPHS OF THE BENEFICIARIES

RELATIONSHIP & NAME				
.....Self.....	.....	.....	.....	.....
.....	.....	.....	.....	.....

Date.....

Signature of Applicant