# 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):**

| SN | NAME IN FULL | DATE OF BIRTH | RELATIONSHIP | STAMP SIZE PHOTO |
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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)