

**DECLARATION FORM**

(For Leave Travel Concession and Medical Facility)

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

**DETAILS OF FAMILY**

(i) Husband, Wife, Children, Step Children

Sl. No.	Name	Relationship	Date of Birth	Occupation	Remarks

(ii) Father, Mother/Minor Brothers/Sisters/Widowed Daughters/Widowed Sisters, residing with me.

Sl. No.	Name	Relationship	Date of Birth	Occupation	Status Married/ Unmarried/ Widowed	Remarks

**UNDERTAKING**

**I undertake that:-**

1. The Children/step children claimed to be dependent do not have income exceeding Rs.9000/- per month.
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.9000/- per month. (If anyone mother/father has the said income, both of them will come under dependents category)
3. My father is not alive/my father is wholly dependent on me and income of my widowed sisters/unmarried sisters does not exceed Rs.9000/- per month from all sources for each person.
4. In case of any changes in the status of the above mentioned persons in future, the same should also be intimated jointly.
5. Acceptance of the declaration by the competent authority in the Spouse's office should be submitted along with the declaration failing which it would not be accepted.
6. I hereby declare that the facts given by me above are to the best of my knowledge, correct. If any of the facts herein mentioned are found to be incorrect or false at a future date, I shall be liable for disciplinary action.

Date:

Signature: .....

Name: .....

FORWARDED

Designation: .....

(Head of the Department)

Department: .....

Employee No: .....

**Note:** Children getting stipend or scholarship exceeding Rs.9000/- per month will not be entailed for LTC but they will be eligible for Medical Facilities.