Form KBF 10A

KARUNYA BENEVOLENT FUND

REIMBURSEMENT OF CLAIMS

* CONSOLIDATED STATEMENT OF BILLS & VOUCHERS

(To be attached with Bills & vouchers)

Name of Govt. Hospital:			**Name of Consulting Doctor:**		
Period of treatment			**From**		**To**
Sl. No	**Date**	**Name of Firm from which bill/voucher issued**	**Bill/ Voucher No.**	**Amount**	
		Total			

Place:

Date: **(Seal)** **Signature of the Consulting Doctor**

*** Add more sheets if needed**