

GOA LABOUR WELFARE BOARD

SCHEME No. XIV

SCHEME FOR T.B. DOMICILIARY TREATMENT OF EMPLOYEES COVERED UNDER THE GOA LABOUR WELFARE FUND ACT, 1986.

1. For Workers/Employees suffering from T.B, domiciliary treatment for recoument is very essential, as hospitalization for a longer period is not considered necessary.
2. Keeping in view the above position, the employees/workers who have been advised domiciliary treatment shall be eligible for facilities under the scheme for a period not exceeding nine months or till the date of issue of fitness certificate whichever is earlier.
3. Only those workers suffering from T.B. and undergoing domiciliary treatment through approved dispensaries, Health centres run by State Government shall be entitled to be following benefits under the scheme.
 - I) **MEDICAL TREATMENT:** Treatment charges not exceeding Rs. 300/- p.m. to each worker to cover the cost of the medicine etc. Only the amount actually incurred shall be reimbursed by the Fund provided it is considered reasonable.
 - II) **SUBSISTENCE ALLOWANCE:** Payment of subsistence allowance subject to a maximum of Rs. 1000/- p.m. to the dependent of worker undergoing domiciliary treatment for T.B. where the worker happens to be the only earning member of the family and he has no other source of income and Rs. 400/- p.m. where the dependents are more than one. No allowance will be given to a woman patient whose husband is working or in case where patient happens to be dependent of workers.

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APPLICATION FORM FOR CLAIMING TREATMENT CHARGE BY WORKERS UNDER THE DOMICILIARY TREATMENT OF T.B. SCHEME.

1. Name in full of the worker :
2. The name and address in full of the :
Industrial Establishment
3. Date of his / her employment and :
total continues service in the
Industrial Establishment
4. Designation or nature of his/her :
employment
5. His/her monthly salary/wages :
(excluding bonus)
6. The Dispensary / Hospital where :
the worker is undergoing
domiciliary treatment of T.B.

Date:

**Signature:
Name:**

ATTESTATION OF THE MANAGER/OWNER

It is certified that Shri/Smt. _____ is employed in his
establishment as _____ continuously for _____ years _____ months.

It is certified that the statement made by the applicant against Cols. 1 to 6 above have been
verified and found to be correct.

Date:

SEAL

**Signature of the Manager/Owner
Name & Address of the Establishment**

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CERTIFICATE OF THE MEDICAL OFFICER

Shri./Smt _____ is employed in _____ and whose signature/thumb impression is given here under, was examined by me on _____ and found to be suffering from T.B. According to my opinion he/she has to receive regular domiciliary treatment for T.B.

Date:

Seal

Signature:

Name: