

**INDIAN PHARMACOPOEIA COMMISSION**  
**Ministry of Health & Family Welfare, Government of India**  
**Sector-23, Raj Nagar, Ghaziabad -201002**

**NEWS PAPERS REIMBUREMENT CLAIM FORM**

**Name of the officer** : \_\_\_\_\_  
**Designation** : \_\_\_\_\_  
**Department** : \_\_\_\_\_  
**Pay Level & Basic Pay (Rs.)** : \_\_\_\_\_

I certify that I have spent Rs. \_\_\_\_\_ (in Rs. \_\_\_\_\_ Only)  
towards purchase of Newspaper(s) for the months of:

- i. January – June, 20\_\_\_\_\_
- ii. July – December, 20\_\_\_\_\_

I further declare that: i) The Newspaper(s) in respect of which reimbursement is claimed, is/are purchased by me. ii) The amount for which reimbursement is being claimed has actually been paid by me and has not/will not be claimed by any other source.

Signature \_\_\_\_\_

Name \_\_\_\_\_

Designation \_\_\_\_\_

Date \_\_\_\_\_

**Note:** This bill should be prepared in duplicate copy also (one for payment and the other as office copy).

---

**FOR OFFICIAL USE ONLY**

Entry has been made at the Page No. \_\_\_\_\_ of the relevant register. Verified and claim admitted/recommended for an amount of Rs. \_\_\_\_\_ Payment may be through Cheque/Cash in favour of \_\_\_\_\_.

Checked By:

Administrative Officer