NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE

BILL FOR CONVEYANCE CHARGES

Claimant's Name _____

Dated	Particulars viz place and purpose of visit	Amount
	Total	

"Certified that the conveyance charges Rs. _____ (Rupees _____) claimed by me during the month of _____ amount of Rs. _____) is including this bill."

Signature of Claimant

Recommendation of the Head of Department/Section.

Dy, Director (Admn.) for approval please.