c

F#2.6

**Dh. Atoll Education Centre**

Dh. Kudahuvadhoo

Medical Bill Submission Form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| General Information | | | | |
| Name: | |  | | |
| PP Number: | |  | | |
| Designation: | | Teacher | | |
|  | |  | | |
| Medical Bill Information | |  | | |
| # | Bill Number | Shop/Hospital Name | Details | Amount |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Total: | | | | 780.00 |
| Here by I agree that above information is Correct:  Name:  Date: Sign: | | | | |
| Payable Amount: | | | |  |