Annexure-I

CLAIM FORM FOR FAMILY PLANNING INDEMNITY SCHEME

The State will ensure that Claim Form cum Medical Certificate required for submitting claims under the FPIS Scheme are made available with all medical facilities conducting sterilization procedures, Office of CMO/CDMO/CMHO/CDHMO/ DMO/DHO/ Joint Director designated for this purpose at district level etc. in local language along with their English version.

1. This form is required to be completed for lodging claim under Section-I of the scheme.
2. This form is issued without admission of liability and must be completed and returned to the District Health Society/State Health Society for processing of claim.
3. **No claim can be admitted unless certified by the convener of QAC/CMO/ CDMO/ CMHO/ CDHMO/DMO/DHO/ JOINT DIRECTOR designated for this purpose at district level by the State Government.**

Claim no. : _____

1. Details of the Claimant:

Name in full: _____ Present Age: _____ Years

Relationship with the acceptor of Sterilization: _____

Residential Address:

_____

_____ Telephone no. _____

2. Details of the person undergone sterilization operation:

Name in Full: _____ Age: _____ Years

Son /daughter of: _____

Name of the Spouse: _____ Age of the Spouse: _____Years

Address: _____

3. Permanent Business or Occupation: _____

4. Details of Dependent children:

S. No.	Name	Age (Yrs)	Sex (M/F)	Whether Unmarried	If unmarried, Whether dependent
1					
2					
3					
4					
5					

5. **(a) Date of Sterilization Operation:**_____

(b) Nature of Sterilization operation:

(i) Laparoscopic Tubectomy: _____

(ii) Vasectomy: _____

(iii) MTP followed by sterilization: _____

(iv) Caesarean operation followed by Sterilization: _____

(v) Any other surgery followed by sterilization: _____

6. (a) Name and address of the doctor who conducted the operation:

_____

(b) Name and address of the hospital where operation was conducted:

_____

(c) **Nature of claim:**

1) **Failure of sterilization** not leading to child birth :_____

2) **Failure of Sterilization** leading to child birth: _____

3) **Medical Complication** due to Sterilization (state exact nature of complication):

a. Date: _____

b. Details of Complication:_____

c. Doctor /Health facility: _____

(d) **Death following sterilization:**

a. Date of Admission: _____ Time:_____

b. Date of Discharge :_____ Time:_____

c. Date of Death:_____ Time:_____

7. Give details of any disease suffered by acceptor prior to undergoing sterilization operation:

_____

I HEREBY DECLARE that the particulars are true to the best of my knowledge and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made, or shall make any false of untrue statement, suppression or concealment of fact, my right to the compensation shall be absolutely forfeited.

I hereby claim a sum of Rs._____/- under the scheme, which I agree in full settlement of my claim and shall have no further right whatsoever to claim under the scheme.

Date: _____ **Name of Acceptor/Claimant: _____**

Place: _____ **Signature (in full) or thumb impression**

MEDICAL CERTIFICATE ISSUED BY CMO/CDMO/CMHO/CDHMO/ DMO/DHO/JOINT DIRECTOR DESIGNATED FOR THIS PURPOSE AT DISTRICT LEVEL.

It is certified that Smt/Shri. _____

S/o/W/o: _____

r/o_____

had undergone sterilization operation on_____ at _____ (hospital)

and conducted by Dr. _____ Qualifications _____

posted at _____

Nature of Sterilization operation done:

(i) Laparoscopic Tubectomy: _____

(ii) Vasectomy: _____

(iii) MTP followed by Sterilization: _____

(iv) Caesarean operation followed by Sterilization: _____

(v) Any other surgery followed by Sterilization: _____

I have examined all the medical records and documents and hereby conclude that the sterilization operation is the antecedent cause of:

(a) **Failure of Sterilization** not leading to child birth: (____) **(Attach documentary evidence)**

(b) **Failure of Sterilization** leading to child birth: (____) **(Attach documentary evidence).**

(c) **Medical Complication:** (please give the details as under)

(i) Nature of Complication:_____ _____

(ii) Period: _____

(iii) Expenses incurred for treatment of complication Rs. _____ **(Attach Original Bills/Receipts/Prescriptions)**

(d) Death of Person (cause): _____

a. Date of Admission: _____ Time: _____

b. Date of Discharge:_____ Time: _____

c. Date of Death: _____ Time: _____ **(Attach death certificate)**

I have further examined all the particulars stated in the claim form and are in conformity with my findings and is eligible for a compensation of Rs..... due to..... (Cause).

Please pay Rs..... to the beneficiary.

Documents enclosed:

(a) Original Claim cum Medical certificate ( )
(b) Attested copy of sterilization certificate ( )
(c) Attested copy of consent form ( )
(d) _____ ( )
(e) _____ ( )

Signature:
Name:
Telephone no.:
Designation:

Date:..... **Seal:**

Annexure-II

APPLICATION CUM CONSENT FORM FOR STERILIZATION OPERATION

An informed consent is to be taken from all acceptors of sterilization before the performance of the surgery as per the consent form placed below

Name of Health Facility: .....

Beneficiary Hosp Registration Number: ..... **Date:** ...../...../20.....

1. **Name of the Acceptor:** Shri/Smt. .....

2. **Name of Husband /Wife:** Shri/Smt. .....

Address .....

Contact No: .....

3. Names of all living, unmarried dependent Children

i) .....Age.....

ii).....Age.....

iii).....Age.....

iv).....Age.....

4. Father's Name of beneficiary: Shri.....

Address: .....

5. Religion/Nationality: .....

6. Educational Qualifications: .....

7. Business/Occupation: .....

8. Operating Centre: .....

I, Smt/Shri ..... (Beneficiary) hereby give consent for my sterilization operation. I am married and my husband/wife is alive. My age is **... years** and my husband/wife's age is **... years**. I have ... (Nos.) male and .... (Nos.) female living children. The age of my youngest living child is ..... years.

 # I am aware that I have the option of deciding against the sterilization procedure at any time without sacrificing my rights to other reproductive health services.

a) I have decided to undergo the sterilization / re-sterilization operation on my own without any outside pressure, inducement or force. I declare that I / my spouse has not been sterilized previously **(may not be applicable in case of re-sterilization**). **(....)**

(b) I am aware that other methods of contraception are available to me. I know that for all practical purposes this operation is permanent and I also know that there are still some chances of failure of the operation for which the operating doctor and health facility will not be held responsible by me or by my relatives or any other person whomsoever **(....)**

(c) I am aware that I am undergoing an operation, which carries an element of risk. **(....)**

(d) The eligibility criteria for the operation have been explained to me, and I affirm that I am eligible to undergo the operation according to the criteria. **(....)**

(e) I agree to undergo the operation under any type of anaesthesia, which the doctor/health facility thinks suitable for me, and to be given other medicines as considered appropriate by the doctor/health facility concerned. **(...)**

(f) If, after the sterilization operation, I experience a missed menstrual cycle, then I shall report within two weeks of the missed menstrual cycle to the doctor/health facility and may avail of the facility to get an MTP done free of cost. **(...)**

(g) **In case of complications following sterilization operation, including failure, and the unlikely event of death following sterilization, I/my spouse and dependent unmarried children will accept the compensation as per the existing provisions of the Government of India "Family Planning Indemnity Scheme" as full and final settlement and will not be entitled to claim any compensation over and above the compensation offered under the "Family Planning Indemnity Scheme" from any court of law in this regard or any other compensation for upbringing of the child. (...)**

(h) I agree to come for follow-up visits to the Hospital/Institution/Doctor/health facility as instructed, failing which I shall be responsible for the consequences, if any. **(...)**

(i) I understand that Vasectomy does not result in immediate sterilization. *I agree to come for semen analysis **3 months after the operation** to conform the success of sterilization surgery (Azoospermia) failing which I shall be responsible for the consequences, if any. **(...)**

(* Applicable for male sterilization cases)

I have read the above information.

#The above information has been read out and explained to me in my own language and that this form has the authority of a legal document.

Date: ..... **Signature or Thumb Impression of the Acceptor**

Name of acceptor: .....

Signature of Witness (Acceptors side):

Full Name: .....

Signature of witness: .....

Full Address.....

 # (Only applicable for those beneficiaries who cannot read and write)

Applicable to cases where the client cannot read and the above information is read out.

Shri/Smt ..... has read/have been fully explained about the contents of the Informed Consent Form in his/her local language.

Signature of Counselor: .....

Full Name: .....

Date: ..... **Full Address: .....**

I certify that I have satisfied myself that -

a. Shri/Smt.....is within the eligible age-group and is medically fit for the sterilization operation.

b. I have explained all clauses to the client and that this form has the authority of a legal document.

c. I have filled the Medical record–cum-checklist and followed the standards for sterilization procedures laid down by the Government of India.

Signature of Operating Doctor

(Name of Operating Doctor)

Date: .....

Seal

Signature of Medical Officer in-charge of the Facility

(Name of Medical Officer in-charge of the Facility)

Date: .....

Seal

DENIAL OF STERILIZATION

I certify that Shri/Smt.....is not a suitable client for re-sterilization/ sterilization for the following reasons:

1. .....

2. .....

He/ She has been advised the following alternative methods of contraception.

1. .....

2. .....

Signature of the Counsellor or**

Doctor making the decision

Date: ..... **Name and full Address: .....**

(** Counsellor can be any health personnel including doctor)

Annexure-III

MEDICAL RECORD & CHECK LIST FOR FEMALE / MALE STERILIZATION

(TO BE FILLED BEFORE COMMENCING THE OPERATION)

A checklist to be filled by the doctor before conducting sterilization procedure for ensuring the eligibility and fitness of the acceptor for sterilization. **This annexure is a part of Consent form.**

NAME OF HEALTH FACILITY: .....

BENEFICIARY REGISTRATION NUMBER: .....DATE: .....

A. ELIGIBILITY

Client is within eligible age	Yes..... No.....
Client is ever married	Yes..... No.....
Client has at least one child more than one year old	Yes..... No.....
Lab investigations (Hb, urine) undertaken are within normal limits	Yes..... No.....
Medical status as per clinical observation is within normal limits	Yes..... No.....
Mental status as per clinical observation is normal	Yes..... No.....
Local examination done is normal	Yes..... No.....
Informed consent given by the client	Yes..... No.....
Explained to the client that consent form has authority as legal document	Yes..... No.....
Abdominal/pelvic examination has been done in the female and is WNL	Yes..... No.....
Infection prevention practices as per laid down standards	Yes..... No.....

B. MEDICAL HISTORY

Recent medical Illness	Yes..... No.....
Previous Surgery	Yes..... No.....
Allergies to medication	Yes..... No.....
Bleeding Disorder	Yes..... No.....
Anemia	Yes..... No.....
Diabetes	Yes..... No.....
Jaundice or liver disorder	Yes..... No.....
RTI/STI/PID	Yes..... No.....
Convulsive disorder	Yes..... No.....
Tuberculosis	Yes..... No.....
Malaria	Yes..... No.....
Asthma	Yes..... No.....
Heart Disease	Yes..... No.....
Hypertension	Yes..... No.....

	Mental Illness	Yes..... No.....
	Sexual Problems	Yes..... No.....
	Prostatitis	Yes..... No.....
	Epididymitis	Yes..... No.....
	H/O Blood Transfusion	Yes..... No.....
	Gynecological problems	Yes..... No.....
	Currently on medication (if yes specify)	Yes..... No.....
	LMP	Date:

Comments.....

.....

.....

C. PHYSICAL EXAMINATION

BP.....Pulse.....Temperature.....

	Lungs	Normal..... Abnormal.....
	Heart	Normal..... Abnormal.....
	Abdomen	Normal..... Abnormal.....

D. LOCAL EXAMINATION

1. MALE STERILIZATION

	Skin of Scrotum	Normal..... Abnormal.....
	Testis	Normal..... Abnormal.....
	Epididymis	Normal..... Abnormal.....
	Hydrocele	Yes..... No.....
	Varicocele	Yes..... No.....
	Hernia	Yes..... No.....
	Vas Deferens	Normal..... Abnormal.....
	Both Vas Palpable	Yes..... No.....

2. FEMALE STERILIZATION

	External Genitalia	Normal..... Abnormal.....
	PV Examination	Normal..... Abnormal.....
	PS Examination	Normal..... Abnormal.....
	Uterus Position	A/V..... R/V..... Mid position..... Not determined.....
	Uterus size	Normal..... Abnormal.....
	Uterus Mobility	Yes..... No.....
	Cervical Erosion	Yes..... No.....
	Adnexa	Normal..... Abnormal.....

Comments.....

.....

.....

E. LABORATORY INVESTIGATIONS

Hemoglobin level	.....Gms%
Urine: Albumin	Yes..... No.....
Urine- Sugar	Present..... Absent.....
Urine test for Pregnancy	Positive: ..... Negative: .....
Any Other (specify)	.....
	.....
	.....
	.....

Name:

Signature of the Examining Doctor

Date:

HOSPITAL SEAL

Annexure–IV

STERILIZATION CERTIFICATE

Reg P.No

S.No

Year

This is to certify that Smt/Shri _____ (Hosp. No.) _____

S/o/W/o.Sri: _____. (He/ She is working as _____

residing at _____

has undergone Vasectomy/Tubectomy operation in _____(name of the facility/hospital) on_____ _____

Sperm count was undertaken on _____ and on the basis thereof it is certified that the Vasectomy operation has been completely successful.

(Para 2 only in case of Vasectomy operation only)

Signature

Medical Officer

Name

Date

Seal

Annexure–V

CHECKLIST FOR SUBMISSION OF CLAIM UNDER FAMILY PLANNING INDEMNITY SCHEME

Before forwarding the Claim Form cum Medical Certificate and other required documents a checklist *for assisting the CMO/CDMO/CMHO/ CDHMO /DMO/DHO/Joint Director designated for* this purpose at district level has been prepared.

CHECK LIST

Before forwarding the Claim Form and other Required Document, it has to be checked that:

A. CONSENT FORM:

1. **Registration number of the beneficiary, date,** and signature or thumb impression of the acceptor are properly placed in respective columns.
2. **Examination of patient record** is filled in properly and doctor has put his signature and date.
3. **Details of dependents** of acceptor are filled in.
4. All columns of Consent form and Medical Record & Check List for female / male sterilization are filled properly

B. CLAIM FORM:

1. Claim is submitted in a prescribed **Claim Form in original.**
2. Claim **forwarded through Medical Officer/Health Facility** conducting sterilization procedures.
3. **Name and address of the acceptor** are same mentioned on Consent form.
4. **Signature or thumb impression of acceptor** is same as mentioned on Consent form.
5. **Date of sterilization** is same as mentioned in the Sterilization Certificate and Consent form.
6. **Other details filled in are tallied** with other relevant documents which are becoming part of claim form.
7. **All columns of Medical Certificate** which is a part of Claim Form are filled in and date, signature and seal of CMO/ CDMO/ CMHO/ CDHMO/ DMO/ Joint Director designated for this purpose at district level has been placed.

C. STERILIZATION CERTIFICATE:

1. **Name of acceptor** is same as filled in on Consent form.
2. **Date of sterilization** is mentioned under specific column.
3. **Certificate issued** have signature and date of issuing authority.
4. Sterilization Certificate is in **proper format as prescribed by the State** and having **Registration Number and date.**

D. DIAGNOSTIC REPORT ISSUED FOR FAILURE OF STERILIZATION:

1. **Report issued should be in a proper document** i.e. hospital case sheet/ proper diagnostic report.
2. It should have **registration number and date.**
3. Cause detected for **failure has been properly recorded** by the issuing authority on the document.
4. First **diagnostic report by which a failure is detected is attached**.

E. BIRTH CERTIFICATE:

1. Issued on a **proper format.**
2. **Name of the acceptor** tallies with other records.
3. **Date of birth** has been properly recorded.
4. The certificate is **signed and duly stamped** with date by proper authority.

F. COMPLICATIONS:

1. The case sheet / prescription have the **name of acceptor.**
2. Case sheet/ prescription have proper **hospital registration number and date.**
3. Case sheet/ prescription have a **date of sterilization.**
4. **Nature of post operative complication** has been recorded.
5. **Medicines prescribed** should tally with cash memo.
6. Case sheet/prescription and bills/cash memo **are in original.**

G. DEATH CERTIFICATE:

1. Death certificate has been issued by the **proper authority.**
2. **Name of diseased, date of death** etc are rightly filled in on the certificate.
3. Certificate should have **registration number and date of issue and signature** of issuing authority.

11	Describe in detail what happened in chronological order. Include all symptoms and signs and describe all actions taken during the course of addressing the complication(s), beginning with the initial identification of the problem until the occurrence of death. Whenever possible record the time and date of each incident. (Use an additional sheet of paper if more space is required.)	…… …… …… …… …… …… …… …… …… …… …… …… ……
12	Cause of death	…… …… …… ……
13	Contributing factors (if any)	…… …… …… ……
14	Was a post-mortem examination performed?	Yes…… No…… **If yes, describe the pertinent findings** …… …… …… …… …… ……
15	Name and designation of surgeon who performed the sterilization operation	…… …… …… ……
16	Name and address of Institution where death occurred	…… …… …… ……
17	Name and designation of reporting officer	…… …… ……

Date
Name

Signature of Reporting Officer
Designation