Shri Amarnathji Yatra 2017

YATRA PERMIT
APPLICATION FORM
(Please fill in block letters)

Applicant's photograph which should be signed across this photograph

FULL NAME: _____ _____

GENDER (Tick ☐ as applicable): Male ☐ Female; ☐ Age*:_____ Yrs; Blood Group:_____

NAME OF SPOUSE / FATHER:_____

ADDRESS:_____

STATE:_____ PIN_____

E-Mail (if any):_____

CONTACT / PHONE NO ☐☐☐☐☐ ☐☐☐☐☐☐☐☐ MOBILE +91 ☐☐☐☐☐☐☐☐☐☐

Telephone with STD Code / Mobile number of the person to be contacted in case of any emergency

_____

✓

To
The Chief Executive Officer,
Shri Amarnathji Shrine Board,
Jammu / Srinagar.

Sir,

1. I may please be issued a Permit for embarking on Shri Amarnathji Yatra. I shall start the Yatra from the _____ _____ [Baltal / Chandanwari**] route on_____ / _____2017.

2. I certify that I have been declared physically fit by the Authorised Doctor / Medical Institute to undertake the journey to the Shri Amarnathji Holy Cave during June-August 2017. The prescribed Medical Certificate is attached.

3. I_____ , son / daughter / wife of_____ , nominate Shri / Smt. _____ ; age _____ ; relationship: _____to be paid the Insurance proceeds*** upon payment of the Insurance claim in case of my death due to accident.

4. I solemnly undertake to abide by the Dos & Don'ts / other directions issued by the Shrine Board / District Administration.

_____
Full Signature of Applicant

* No one below the age of 13 years, or above the age of 75 years, and no lady with more than six weeks pregnancy will be registered for the Yatra.
Please fill whichever is applicable.
*** A duly registered Yatri with a valid Yatra Permit issued by the Shri Amarnathji Shrine Board, duly endorsed by the issuing Institution, will be entitled to an Insurance cover of One Lac Rupee from the Insurance Company in the event of his/her death due to any accident inside the State of J&K while undertaking the Shri Amarnathji Yatra. The sum assured will be paid through the Shrine Board after the nominee of the deceased Yatri completes the due formalities.

For Office Use **Business Unit** _____ **Branch**

Bank Yatra Registration Slip No. _____ Date _____ Route _____ issued

Seal and Signature of
Registration Officer

Initials of Official

COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2017

Please paste one recent passport size photograph here

PART A: (TO BE FILLED BY APPLICANT)

1. Name _____S/o;D/o; W/o _____

   Address _____

2. Date of Birth _____ Identification mark: _____ Blood Group:_____

3. **DECLARATION: Have you suffered from or have history of any of the following:**

a) Breathlessness	☐ Yes ☐ No	b) Diabetes	☐ Yes ☐ No
c) Respiratory/ lung ailment	☐ Yes ☐ No	d) High Blood pressure	☐ Yes ☐ No
e) Blood disorder	☐ Yes ☐ No	f) Asthma	☐ Yes ☐ No
g) Bleeding tendencies	☐ Yes ☐ No	h) Epilepsy	☐ Yes ☐ No
i) Heart ailment	☐ Yes ☐ No	j) Nervous breakdown	☐ Yes ☐ No
k) Joint Pains	☐ Yes ☐ No	l) High altitude/mountain sickness	☐ Yes ☐ No
m) Discharge from ear	☐ Yes ☐ No	n) History of stroke/ paralysis	☐ Yes ☐ No
o) Are you a smoker	☐ Yes ☐ No	p) Are you pregnant: (*applicable to female Yatris*)	☐ Yes ☐ No

   q) History of Heart Attack; if yes, please specify_____

   r) History of sudden death in family members; if yes, please specify_____

   s) Any major injury in the past; if yes, please specify_____

   t) Any other ailment; if yes, please specify_____

   u) History of surgery; if yes, please specify_____

   v) Are you undergoing under any medication; if yes, please specify_____

   w) Are you allergic to drugs, foods and chemicals; if yes, please specify_____

4. I hereby declare that the particulars given above are true to the best of my knowledge and belief,, and nothing has been concealed.

Date_____ **Signature/ thumb impression of the Applicant)**

PART B: (TO BE FILLED BY AUTHORISED MEDICAL AUTHORITY)

On the basis of information furnished by the applicant, detailed examination and the necessary investigations, it is certified that Mr/Ms/Mrs _____ is fit to undertake the journey to the Shri Amarnathji Holy Cave Shrine.

Details of any specific test conducted before issuing the certificate: _____

Name of the Doctor_____

Designation:_____ **Signature and seal of Authorized Medical Authority**

Date of issue:_____ **MCI/ State Medical Council Registration No:**_____