WEST ZONE POWER DISTRIBUTION COMPANY LIMITED

Medical Bill Reimbursement Claim

Name : Date :

Designation : Office:

S.N.	Name of the Patient	Relation	Purpose	Amount in Taka
				-
				-
				-
			Total Taka :	-

(Taka …….. only)

*** Bils enclosed**

Submitted by :

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Checked by : Approved by : Received by:

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