OFFICE OF THE REGISTRAR
Indian Institute of Engineering Science and Technology, Shibpur
(Formerly Bengal Engineering and Science University, Shibpur)
P.O.: Botanical Garden
Howrah – 711 103

No.:- RMS/474/25

Date: 16 Sept., 2025

NOTICE

Sub. – Submission of Family Declaration for updation

All employees (Teaching and Non-Teaching) are hereby requested to kindly submit their Family Declaration in the attached format by 29.9.2025 in the Receiving Section for updation of the Institute records.

This is issued with the concurrence of the competent authority.

Enclo:- as stated above

15/9/25

(Shib Sankar Basak)
Dy. Registrar (Establ.-II)

Memo No..: RMS/474/25 (7)

Date: 16 Sept., 2025

Copy forwarded for information, wide circulation and necessary action to:

1. The PS to the Director
2. All Deans
3. All Head of the Departments/Schools/Centres
4. All Hostel Superintendents
5. All Officers/Section In Charges
6. Institute Website
7. Record Section – for guard file.

15/9/25

Dy. Registrar (Establ.-II)

Notice for Family Declaration for updation/Partha, Supdt., SG-II/03.9.2025

FAMILY DECLARATION FORM

1. Name :_____

2. Designation :_____ 3. Department:_____

4. Pay Band :_____ 5. (Academic) Grade Pay :_____

6. Employee Code :_____ 7. Gross Salary : _____

8. Contact No. : _____ 9. Blood Group:_____

10. Date of Birth :_____ 11. Date of Superannuation:_____

12. Residential Address :_____

_____

_____

13. Email :_____

14. Details of Dependent's:

Sl. No.	Name(s)	Relationship with the Employee	Date of Birth	Blood Group	Residing with the Employee ? (Y / N)
a.					
b.					
c.					
d.					
e.					

Contd. P/2

15. No. of Dependents:

16. No. of Health Record Books:

17. Declaration:

I do hereby declare to intimate the Institute-authority immediately if any change in dependency criteria of my family members, mentioned in this application form, occurs.

In case I avail myself of the CMS/LTC facility for the dependent who is no more my dependent, suppressing the fact, I will be liable to accept any administrative action against me.

I do hereby declare to surrender the CMS Health Record Book of my dependent on ceasing to be eligible for CMS benefits;

I do hereby certify that the information furnished by me in this application is true to the best of my knowledge and belief. No information is concealed or misrepresented.

Date:

Signature of the Employee

Enclo: (Please use √ mark where applicable)

- Proof of residence / stay of dependants (Ration Card/ EPIC / Passport / Bank Pass Book / Identity Card issued by College / school/University etc.)
- Proof of age of son /dependant brother
- Disability certificate, if age of son is above 25 years
- Self certified copy of blood group report.