केन्द्रीय विद्यालय संगठन(मुख्यालय)
KENDRIYA VIDYALAYA SANGATHAN (HQ)
शिक्षा मंत्रालय भारत सरकार के अधीन स्वायत संस्थान
An Autonomous Body Under Ministry of Education, Govt. of India
18 संस्थागत क्षेत्र/18 Institutional Area,
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केन्द्रीय विद्यालय संगठन

No. F.1-1/2023/KVS HQ (Estt-II)/3365-3367 Dated: 05.07.2023

NOTIFICATION

KVS has notified its **Transfer Policy-2023** vide notification dated 30.06.2023.

In this context, it is to state that the submission of transfer application forms under various categories will only be accepted in the following formats, whichever applicable:-

a) **Annexure-1 :** Declaration for seeking transfer benefits under PwD Ground.
b) **Annexure-2 :** Declaration for seeking transfer benefit under Spouse Ground.
c) **Annexure-3 :**Declaration for seeking transfer benefit under Medical Ground along with Medical Certificate.
d) **Annexure-4 :** Declaration for seeking transfer benefit under Main Care-Giver to the person with Disability in the family (i.e. spouse or own son/own daughter).
e) **Annexure-5 :** Declaration for seeking transfer benefit of Single Parent.

Ajeeta 05/07/2023
(Ajeeta Longjam)
Joint Commissioner (Admn-1)

Distribution:-

1. **All Deputy Commissioners/Directors/Assistant Commissioners for necessary action and circulation.**
2. **Deputy Commissioner (EDP) with the request to upload the notification on the KVS (HQ) website.**
3. **Guard File.**

Annexure-1

DECLARATION FOR SEEKING TRANSFER BENEFIT UNDER PwD GROUND

I, Sh./Smt/Ms.....(name of the employee), ...(post), solemnly declare and furnish the following details to take transfer benefit under PwD ground:

SN	Particular	Details to furnish
1	**Category of PwD :**	**OH / VH / HH** (strike out whichever is not applicable)
2	**% of Disability:**	
3	**PwD Certificate No.:**	
4	**Date of Issue of the Certificate:**	
5	**Details of the Hospital/Medical Board by which certificate has been issued with address:**	Name:
		Address:
6	**Designation/Rank of Medical Board Officer issued the certificate :**	

The PwD Certificate issued by the Medical Board has been enclosed also.

Signature of the employee

Date: .....

Verified by ASO/SSA/JSA/Any employee delegated by the Controlling Authority
Signature:
Name:
Designation:

Countersigned by the Controlling Officer with stamp
Name:
Designation:

Annexure-2

DECLARATION FOR SEEKING TRANSFER BENEFIT UNDER SPOUSE GROUND

I, Sh./Smt.....(name of the employee), ...(post), solemnly declare that my spouse Sh./Smt ..... (name of the spouse) is working in capacity of ..... (post of the spouse) in ..... (Department name) which is under K V S / Central Government/Central Government PSU/ Central Government Autonomous Body/ State Government/ State Government PSU/ State Government Autonomous Body (strike out whichever is not applicable) and is currently posted at/in ..... (station/place of posting of spouse) which is my present station/ preferred station (strike out whicheveris not applicable). The service certificate of my spouse has been issued on dated..... by the competent authority of the concerned department.

The service certificate as issued from the department of my spouse as stated above has been enclosed also.

Signature of the employee

Date: .....

Verified by ASO/SSA/JSA/Any employee delegated by the Controlling Authority
Signature:
Name:
Designation:

Countersigned by the Controlling Officer with stamp

Name:

Designation:

Annexure-3

P-1/3

DECLARATION FOR SEEKING TRANSFER BENEFIT UNDER MEDICAL GROUND (MDG)

I, Sh./Smt.....(name of the employee), ... (post), solemnly declare the following details to take transfer benefit under medical ground (MDG ground):

S.N.	Particular	Details to furnish
1	Name of the patient	
2	Relation of the patient with the employee	**Self/ Spouse/ Son/ Daughter** (strike out whichever is not applicable)
3	(i) Medical Certificate No.	
	(ii) Date of Issue of Certificate	
	(iii) Hospital name with full address	
	(iv) Name of the Medical Officer who has issued the certificate	Name: Address:
	(v) Designation/Rank of the Medical Officer	
4	Disease Code as per Annexure 1 of KVS Transfer Policy	
5	Brief description of Disease as per Annexure 1 of KVS Transfer Policy	

The medical certificate issued by the Medical Officer as stated above is enclosed also.

Signature of the employee

Date: .....

Verified by ASO/SSA/JSA/Any employee delegated by the Controlling Authority
Signature:
Name:
Designation:

Countersigned by the Controlling Officer with stamp

Name:

Designation:

Annexure-3
P-2/3

MEDICAL CERTIFICATE

(TO AVOID DISQUALIFICATION, PLEASE DO NOT USE ABBREVIATION, FILL IN CAPITAL LETTERS ONLY. PLEASE DO NOT ATTACH ANY ENCLOSURE EXCEPT WHERE SPECIFICALLY ASKED FOR)

Name of Patient: _____

Relation of the patient with the employee: _____
(Self/spouse/dependent son/dependent daughter)

Address of the Doctor

_____

_____

_____

Contact No. _____(Land Line)

_____(Mobile)

Date: _____

Certificate

I, Dr. _____ with Medical Council Registration No._____hereby certify that Shri/Smt./Ms./Miss/Master_____ aged _____Gender_____*who himself/herself is a KVS employee or *dependent son/ dependent daughter/wife/husband of Sh./Smt./Ms. _____ (Name of KVS employee) is suffering from the disease/diseases with the details as follows and that treatment of this disease is not at all available at this station or in its vicinity (*Strike off whichever is not applicable).

1) **IN CASE OF CANCER**
   1. Type of cancer with site affected:
   2. Date when it was detected first:
   3. Brief history-Pathological report with reference No. & dates:

      _____

      _____
   4. T.N.M. classification (if applicable):
   5. Evidences in support of uncontrolled growth
   6. Evidences in support Metastasis:
   7. Condition of neighboring or surrounding structures:
   8. Treatment being continued (in brief):
   9. Full name of surgery/surgeries in connection with dates:

2) **IN CASE OF PARALYTIC STROKE**
   1. How many extremities are affected?
   2. Grading of muscle power at present:
   3. Grading of muscle power at the onset of disease:
   4. Duration of loss of muscle power:
   5. Any recovery after the onset till date:
   6. Most Direct cause of loss of Muscle Power:

3) **IN CASE OF RENAL FAILURE**
   1. Name of disease-causing Renal failure:
   2. Evidences in support of Chronic Irreversible changes:
   3. Number of Dialysis done with dates:
   4. Kidneys involved (single/both):
   5. Any surgery including renal transplantation done (Yes/No):

4) **IN CASE OF CORONARY ARTERY DISEASE**
   1. Name of the surgical procedure undergone. CABG/Angioplasy:
   2. Date of surgical procedure:
   3. Name of Doctor-Surgeon:
   4. Name of Hospital:

5) **IN CASE OF THALASSEMIA**
   1. Name of disease (with specification- major or minor):
   2. Date of first detection:
   3. Whether blood transfusion required? (Yes/No):
   4. If so, periodicity of duration of blood transfusion/replacement required by the patient/chelation therapy:
   5. Blood transfusion done last:_____(DD/MM/YYYY)

6) **IN CASE OF PARKINSON'S DISEASE**
   1. Date of detection of disease:
   2. Duration of treatment undergone:
   3. Date & designation of treating Neurologist:
   4. Whether admitted in hospital & if so, details thereof:
   5. Progressiveness of the disease- please specify:
      (To be certified by a neurologist)

7) **IN CASE OF MOTOR - NEURON DISEASE**
   1. Date of detection of the disease:
   2. Duration of treatment undergone:
   3. Name & designation of the treating neurologist :
   4. Result of EMG test report & MRI:
   5. Grading of muscle power at present:

8) Any other disease with more than 50% mental disability duly examined by and recommended by the Regional Medical Board with latest records/reports (within last three months):

_____

_____

9) AIDS
   1. Date of detection of the disease:
   2. Duration of treatment undergone:

(The Doctor is requested to "Cross" 1/2/3/4/5/6/7/8/9 above whichever is not applicable in the case of the Patient)

Place : _____

Date : _____

(Signature of the Civil Surgeon)
Name _____
Name of the Deptt. _____
Name of the Hospital _____

Seal:

Signature and name of the
KVS employee (applicant) : _____

Signature and Name of the Patient: _____

(If the certifying doctor is below the rank of Civil Surgeon or equivalent the certificate should be countersigned by a doctor of the rank of Civil Surgeon or equivalent)

Annexure-4

DECLARATION FOR SEEKING TRANSFER BENEFIT UNDER MAIN CARE-GIVER TO THE PERSON WITH DISABILITY IN THE FAMILY (i.e. SPOUSE OR OWN SON / OWN DAUGHTER)

I, Sh./Smt/Ms.....(name of the employee), ...(post), solemnly declare and furnish the following details to take transfer benefit under MAIN CARE-GIVER to the person with disability in my Family (i.e. i/r of SPOUSE OR OWN SON OR OWN DAUGHTER):

S.N.	Particular	Details to furnish
1	Whether the **employee him/her self** (as stated above) is Main Care-Giver to the person(i.e. spouse or own son/own daughter) with disability in the family and have a bearing on the systematic rehabilitation of person with disability as per the details in the **para3(viii) of Part-1 of KVS Transfer Policy**	**YES / NO**
2	Name and Age of the family member who is having disability	Name : Age :
3	Relation of the employee with the family member who is having disability with the employee	**Spouse/ Son/ Daughter** (strike out whichever is not applicable)
4	Name the type of disability of the family member as per the details in the **para3(viii) of Part-1 of KVS Transfer Policy**	
5	Percentage of disability	
6	Date of issue of Disability Certificate	
7	Name of the Medical Board/ Hospital which issued the disability certificate with full address	Name: Address:
8	Rank of the Medical Officer who issued the disability certificate	

The certificate of disability issued by the concerned Medical Authority is enclosed also.

Signature of the employee

Date: .....

Verified by ASO/SSA/JSA/Any employee delegated by the Controlling Authority
Signature:
Name:
Designation:

Countersigned by the Controlling Officer with stamp
Name:
Designation:

Annexure-5

DECLARATION FOR SEEKING TRANSFR BENEFIT OF SINGLE PARENT

I, Sh./Smt/Ms..... (name of the employee),.....(post), solemnly declare that I am a single parent of my ward(s) and furnish the following details:

S.N.	Particular	Details to furnish
1	**Name of the ward(s)**	1. 2. 3.
2	**Age of the ward(s)**	1. 2. 3.
3	**Reason for being Single Parent :**	Divorce/ Legal Separation/ Adoption/ Death of Spouse (strike out whichever is not applicable)
4	**Relevant documentary proof attached:** **Any of the following document to be attached for claiming for transfer benefit:** **Legal document for divorce/** **Legal separation documents/** **Legal adoption document for adoption/** **Death certificate for Death of spouse**	(Mention the Type/Name of document attached)

The relevant documentary proof for claiming the transfer benefit under single parent is enclosed also.

Signature of the employee

Date: .....

Verified by ASO/SSA/JSA/Any employee delegated by the Controlling Authority
Signature:
Name:
Designation:

Countersigned by the Controlling Officer with stamp
Name:
Designation: