CERTIFICATE- A

(To be completed in case of patients who are not admitted to hospital for treatment)

Certificate granted to Mr.....

Wife/son/daughter of Mr.....

Employed in the.....

I Dr. .....here by certify

(I) That I charged and received Rs..... for .....

Consultations on.....(date to be given) at my consulting room/ at the residence Of the patient.

(J) That I charged and received Rs.....for administering .....intra-muscular injections/sub-cuteneous on .....(date to be given) at my consulting room/ at the residence of the patient.

(K) That the injections administered were for/ were not immunising or prophylactic Purposes.

(L) That the patient has been under treatment at..... hospital / my consulting room and that the under mentioned medicine prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient The medicines are not stocked in the..... .....(name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available for preparations which are primarily foods toilets or disinfections.

S. No	Bill No.	Date	Price (Rs.)

(E) that the patient is / was suffering from .....
And is / was under my treatment from .....to.....

(N) That the patient is / was not given prenatal or postnatal treatment .
(O) That the X-Ray laboratory test, etc. for which an expenditure of Rs .....
was incurred were necessary and were undertaken on my advice at

.....(Name of hospital or laboratory)

(P) That I reffered the patient to Dr. .....for
specialist consultation and that the necessary approval of the .....

.....(Name of the Chief Administrative Medical Officer Of The State) as required under the rules was obtained.

(Q) That the patient did not require / required hospitalization.

Encl-
Date

(Signature and seal)
Medical Officer of the hospital/
Dispensary to which attached.

N.B. Certificates not applicable should be struck off. Certificate (A) is compulsory and must be filled in by te Medical Officer in all cases.

COUNTERSIGNED

I certify that the patient has been under treatment at the our hospital / Dispensary and that the facilities provided were the minimum which were essential for the patient's treatment.

Place : .....
Date : .....

Signature and seal
Medical Superintendent or
Incharge of hospital/dispensary