

Certificate granted to Mrs./Mr./Miss.....
 Wife/Son/Daughter of Mr.....
 Employed in the.....

CERTIFICATE "A"

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

- I, Dr. hereby certify :-
- (a) that I charged and received ₹ for consultations on (date to be given) at my consulting room..... at the residence of the patient.
- (b) that I charged and received ₹ for administering intramuscular injections/subcutaneous on.....(date to be given) at my consulting room/at the residence of the patient.
- (c) That the injections administered were for/were not for immunizing or prophylactic purposes.
- (d) That the patient has been under treatment at.....hospital/my consulting room and that the undermentioned medicines 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 disinfection.

S.N.	Name of medicines	Prices
1.		
2.		
3.		
4.		
5.		
6.		

- (e) That the patient is/was suffering from..... and is/was under my treatment from.....to.....
- (f) That the patient is/was not given prenatal or postnatal treatment.
- (g) That the X-ray laboratory test, etc. for which an expenditure of ₹ was incurred were necessary and were undertaken on my advice at..... (Name of hospital or laboratory)
- (h) That I referred 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.
- (i) That the patient did not require/required hospitalization.

Signature & Designation of the Medical Officer
 Name of the Hospital/Dispensary to which attached.
 Dated

N.B. :-

Certificate not applicable should be struck off. Certificate (a) is Compulsory and must be filled in by the Medical Officer in all cases.

Certificate granted to Mr./Misswife/son/daughter of Mr./Miss.....employed in the.....

Certificate granted to Mrs./Mr./Miss.....
 Wife/Son/Daughter of Mr.....
 Employed in the.....

CERTIFICATE "B"

(To be Completed in the case of patients who are admitted to hospital for treatment)

PART -A

(To be signed by the Medical Officer in charge of the case at the hospital)

I, Dr. hereby certify :-

- (a) that the patient was admitted to hospital on my advice/the advice of.....
(Name of medical officer).
- (b) that the patient has been under treatment atand that the under mentioned medicines 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 hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available, for preparation which are primarily foods, toilets or disinfection.

S.N.	Name of medicines	Prices
1.		
2.		
3.		
4.		
5.		

- (c) That the injections administered were not for immunizing or prophylactic purposes.
- (d) That the patient is/was suffering from
 and is/was under my treatment fromto.....
- (e) That the X-ray, Laboratory tests, etc. for which an expenditure of ₹
 was incurred were necessary and were undertaken on my advice at.....
 (Name of hospital or laboratory)
- (f) That I called in Dr.(Name of the Chief Administrative Medical Officer of the State), as required under the rules, was obtained.

Signature and Designation of
 The Medical Officer-in-charge

PART -B

I certify that the patient has been under treatment at the.....
hospital and that the services of the special nurses, for which and expenditure of ₹..... was incurred vide bills and receipts attached, were essential for the recovery/prevention of serious deter-oration in the condition of the patient.

Signature of the Medical
 Officer-in-charge of the case at the Hospital

COUNTERSIGNED

Medical Superintendent
Hospital

I certify that the patient has been under treatment at the..... Hospital and that the facilities provided were minimum which were essential for the patients treatment.

Medical Superintendent
Hospital

Place :
 Date :

N.B. :- Certificate not applicable should be struck off. Certificate (d) is Compulsory and must be filled in by the Medical Officer in all cases.

MEDICAL CERTIFICATE OF FITNESS TO BE PRODUCED ON RETURN FROM LEAVE

F.R. 71 (43) A

I CHIEF MEDICAL OFFICER/
AUTHORIZED MEDICAL ATTENDENT do here by certify that we / I have carefully examined
shri/smt. of thedepartment and
find that he has recovered from his illness and now fit to resume duties in government service on
.....

We / I also certify that before arriving at this decision we/I examined the original medical
certificate and statement of case (or copies there of certified by the officer granting the leave) on
which leave was granted and have taken these into consideration on arriving at our/my decision.

Date.....

Place.....

CHIEF MEDICAL OFFICER

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Medical Statement of Shri.....

(Name to be filled in the application in the presence of Chief Medical Officer or the authorized medical attendant)

1. Name.....
2. Appointment held.....
3. Age.....
4. Total Service.....
5. Previous period of leave.....
(Absence on medical certificate).....
6. Habits.....
7. Disease.....
8. History.....
.....
.....

I, Dr. CHIEF MEDICAL OFFICER/ AUTHORIZED
MEDICAL ATTENDENT, ator
of.....after careful and personal examination of the case.
Hereby certify that shri/smt.....is/was in bad state of health and I
solemnly and sincerely declare that according to the best of my judgment, a period of absence from
my duty is/ was essentially necessary for recovery of his/her health and recommend that he/ she
may be granted leave for..... w.e.f.....In my opinion it
is not necessary for the officer to the officer to appear before a medical board.

Date.....

Place.....

CHIEF MEDICAL OFFICER

परिशिष्ट 'ड'

अनिवार्यता प्रमाण-पत्र

प्रमाणित किया जाता है कि श्री/श्रीमती.....
पुत्र/पति/पत्नी श्री.....
आयु.....वर्ष.....
.....

रोग से पीड़ित हैं। इनका उपचार(चिकित्सालय का नाम)
में मरीज की अपरिहार्य परिस्थिति/आकस्मिकता को देखते हुये दिनांक.....से शुरू किया गया।

चिकित्सक का नाम व मुहर

परिशिष्ट 'ग'

(भाग-पाँच-नियम-16 तथा 18 देखें)

सेवा में,

कार्यालयाध्यक्ष का नाम,

.....

.....

विषय :-चिकित्सा उपचार पर किये गये व्यय की प्रतिपूर्ति ।

महोदय,

मैं...../मेरे पारिवारिक सदस्य(नाम).....

ने(बीमारी का नाम) के लिए

(दिनांक) से (दिनांक).....तक

(चिकित्सालय का नाम) में उपचार करवाया है । मैं निम्नलिखित दस्तावेजों के साथ प्रतिपूर्ति के लिए दावा प्रस्तुत

कर रहा हूँ :-

1. उपचारी चिकित्सक/चिकित्सालय के अधीक्षक द्वारा हस्ताक्षरित/प्रतिहस्ताक्षरित अनिवार्यता प्रमाण-पत्र ।
2. उपचारी चिकित्सक द्वारा विधिवत् हस्ताक्षरित एवं सत्यापित मूल नकद पर्ची(कैश मेमो), बीजक(बिल), बाउचर ।
3. यह प्रमाणित किया जाता है कि ऊपर नामित पारिवारिक सदस्य मुझ पर पूर्णतया आश्रित है ।

मेरे उपचारार्थ(कार्यालय का नाम)

के पत्र संख्या.....दिनांक.....द्वारा स्वीकृत ₹ के अग्रिम

का सामायोजन करने के पश्चात् मेरे दावे की प्रतिपूर्ति के लिए यथा आवश्यक कार्यवाही करने की कृपा करें ।

अधिकारी / कर्मचारी का नाम :-.....

पदनाम :-.....

तैनाती का स्थान :-.....

दिनांक :-.....