D-596-2000-M.D.U. Press

MEDICAL CERTIFICATE

(to be filled in Capital Letters)

Name of the Claimant ....Period of treatment ....
Designation .... From ....to ....
Department ....Indoor No............................... Date .... Pay .... P.M.
Outdoor No ....Date...................................

I Certify that Mr./Mrs.. son/daughter/wife/mother/father of Mr/Mrs.. employed in the office of the .... has been under my treatment in the...Hospital/Dispensary in my consultation room and that the under mentioned medicines prescribed by me in this connection were absolutely essential for the recovery/prevention of serious deterioration in the condition of the patient. The medicines were not stocked in the .... (Name of Hospital/Dispensary) for the supply to the patient and do not include preparation for which cheaper substitute of the equal therapeutic value are available nor the preparation prescribed are primarily food/toilets/tonics or disinfectants.

CERTIFIED THAT

1. The medicines have no cheaper and effective substitute.
2. The treatment given was indoor/outdoor.
3. The Price claimed is reasonable.
4. The medicines are not in the nature of tonics or food or vitamins etc. the cost of which is not reimbursable in the Govt, orders issued on this subject from time to time.
5. He/She was suffering from ....

[in capital letter(s)]

Sr. No.	Name & Quantity of medicines (in capital letters)	Outdoor/Indoor ticket No. & date on which prescribed	Date on which actually purchased	Price (Rs.)

Signature & stamp of the A.M.A.

Name in Capital ....

In case of Indoor Treatment

Certified that the medicines claimed in this bill are as per bed head ticket (No. relates to the case.

Signature & stamp of A.M.A.

Certified that:

1. The medicines have actually been purchased by me during the course of treatment.
2. I am living in House No .... Rohtak
3. I have purchased the medicines from the prescribed Co-op. Store
4. The medicines have been purchased from private shop after obtaining non availability certificate from Medical Co-op. Store ....
5. The amount of medicines purchased from private shop against one or more prescriptions does not exceed ? 50/- in a month.
6. Certified that there is no co-operative Store/Super Bazar at... as such medicines have been purchased from private shop.
7. In case of wife/husband/children:

   That the patient Mr./Mrs .... is my.. and he/she is unmarried and unemployed (In case of sons/daughters).
8. For parents only:

   His/her total monthly income does not exceed ? 3500/- p.m. and my mother/father is/are residing with me at...
9. In case spouse is working:

   a) Certified that my wife/husband is not getting any fixed medical allowance from any source.

   b) Certified that my wife/husband is employed and he/she has not claimed reimbursement of any of these medicines. An affidavit to this effect has been given for claiming the reimbursement claim.

   c) Certified that I am not an adhoc employee and an working on regular basis.

Signature of the claimant

Place :

Name (in capital letters) ....

Dated

Designation...