



**DEPENDENT DECLARATION CERTIFICATE**

I ..... (Full  
name & Designation hereby declare that my father / Mother Sri / Smt.  
..... has no property or income of his / her own  
and that he / she is wholly dependent upon me.

Station:

Date:

Signature & Designation

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**NON DRAWAL CERTIFICATE**

Certified that the claim of reimbursement of medical expenses incurred  
by Sri.....retired/working as  
..... on his treatment for  
..... from ..... to ..... at  
..... Hospitals ..... amounting to  
Rs.....(Rupees.....  
..... Only) was neither preferred nor drawn  
previously.

Signature and designation

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**EMERGENCY ADMISSION CERTIFICATE**

This is to certify that Mr. / Mrs./Ms..... S/o. D/o/  
W/o.....aged about.....admitted in  
our hospital in .....Department under emergency on  
..... at ..... am / pm.

The provisional diagnosis is .....

Signature and designation of the  
attending medical authority

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**ESSENTIALITY CERTIFICATE**

I Certify that Mrs. / Mr. / Miss.....  
Wife/Son/Daughter of Mr/Mrs.....employed in  
the..... has been under my treatment for  
.....diseases from .....to  
.....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 the condition of the  
patient . The Medicines are not stocked in the.....Hospital  
( for supply to patients) and do not include proprietary preparations for which  
cheaper substance of equal therapeutic value are available or preparations which  
are primarily foods, toilets of disinfectants.

**Name of Medicines/Bill No.**

**Price**

.....

.....

.....

.....

.....

.....

**Signature and Designation of Authorized Medical Attendant**

**Signature of the Medical Officer in charge in the case of the hospital**

**CERTIFICATE - A**

**(To be completed in the case of patients who are not admitted to hospital for treatment for the following cases only along with ORIGINAL OUT PATIENT (OP) SLIP FROM CONCERNED DOCTOR)**

(Chemotherapy, Radiotherapy for cancer, Regular dialysis for Kidney, Cardinal cases like cardiac cases, Severe neurological problems and A.I.Ds subject)

I, I Dr. .... hereby certify

- a) That I charged Rs. .... for ..... consultation on..... at my consultation room / at the residence of the patient.
- b) That I charged Rs. .... for administering intramuscular/ intravenous / subcutaneous injections on..... (Dose to be given) ay my consulting room at the residence of the patient
- c) That injections administrated repay in formatting or propyloction purpose.
- d) That the patient has been under treatment at .....hospital consulting room and 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 .....hospital and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available or preparations which are primarily foods, tonics, toilets or disinfectants.

Name of the Medicine	Cost
.....	.....
.....	.....
.....	.....

- e) That patient is / was suffering from .....  
And is / was under my treatment from .....
- f) That the patient was / not given prentation post treatment
- g) That the X ray, Laboratory tests etc, for which an expenditure of Rs. .... was incurred was necessary and was under taken on my active at the ..... (name of the hospital or laboratory .
- h) That referred the patient of Dr.....for specialist multilation and that the necessary approval of Director , Medical Service as required under the rules was obtained and
- i) That the patient did not require / required hospital etc.

Date .....

**Signature and Designation  
of the Authorized Medical Attendance**