

**MEDICAL CERTIFICATE FOR AVAILING  
FINANCIAL ASSISTANCE FOR TREATMENT**  
**( To be issued by the Head of the Hospital where  
the patient undergoes treatment )**

- 1. Name and address of the Patient**
  
  
  
  
- 2. OP / IP No. with date of registration /  
admission**
  
  
  
  
- 3. Description of the disease**
  
  
  
  
- 4. Treatment recommended**
  
  
  
  
- 5. Expenditure already incurred, if any.**
  
  
  
  
- 6. Anticipated expenditure of the  
treatment undergoing / recommended**
  
  
  
  
- 7. Remarks**

**Date :**

**Signature and Name of the issuing  
authority and Name and address of  
the Hospital**