

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./Miss .....wife/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 at .....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 ..... (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 from .....to.....  
(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 deterioration 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.

Details of Expenditure for Medical Reimbursement Claim				
Patient Name				Age/Sex-
S.No.	Date	Cash Memo/ Receipt No./Bill No.	Issued from	Amount in ₹
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
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32.				
33.				
34.				

## अपरिहार्य / आपात दशा प्रमाण-पत्र

प्रमाणित किया जाता है कि श्री/ श्रीमती.....  
पुत्र/पति/पत्नी श्री.....आयु.....  
वर्ष.....  
रोग से पीड़ित हैं। इनका उपचार ..... में मरीज  
की अपरिहार्य परिस्थिति/आकस्मिकता को देखते हुये दिनांक.....से शुरू किया गया।

चिकित्सक का नाम व मुहर

स्तम्भ—2  
एतद्वारा प्रतिस्थापित परिशिष्ट  
परिशिष्ट 'ग'  
(भाग—पॉच—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 ..... 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 पर्चा(कैश मेमो), बीजक(बिल), बाउचर।
3. यह प्रमाणित किया जाता है कि ऊपर नामित पारिवारिक सदस्य मुझ पर पूर्णतया आश्रित हैं और सामान्यतया मेरे साथ निवास करता 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।

दिनांक.....

अधिकारी/कर्मचारी का नाम :—.....

पदनाम :—.....

तैनाती का स्थान :—.....