CERTIFICATE-A

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

Certificate granted to Mrs./Mr./Miss._____ Cr. No._____ wife/ Son/daughter of Mr._____ Employed in the _____.

Part-"A"

1 Dr.....hereby certify.

(a) that I charged/received Rs.....for administering .....at my consulting room/at the residence of the patient.

(b) that I Charged and received Rs. .....for administering .....inteamudular/subcutaneous injections on .....at my consulting room/at the residence of the patient.

(c) that I patient has been under treatment at .....hospital/ my consulting room and that the under mentioned medicines by me in this connection were essential for the recovery/ prevention of serious detoriation in the condition of the patient. The medicines are not stocked in the (name of hospital)

Sr. No.	Name of Medicines & Investigations, Procedures	Quantity	Price
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
	Total Amount:-		

Continue.....

(c) That the injections administered were/were not for immunising 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 Rs..... was incurred were necessary and were undertaken on my advice at..... .....

(Name of the hospital or laboratory)

(f) That I referred the patient to Dr.....for specialist consultation and that the necessary approval of the .....

(Name of the Chief Administrative Medical office of the State)

.....as required under the rules was obtained.

Signature and Designation of the
Medical Officer-in-charge of the
Case at the hospital

PART-"B"

I certify that the patient has been under treatment at the ....hospital and that the services of the special nurses for which an expenditure of Rs.....was incurred vide bills and vouchers 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 the facilities provided were the minimum which were essential for the patient's treatment.

..... Medical superintendent.

..... Hospital

आकस्मिकता प्रमाण–पत्र

प्रमाणित किया जाता है कि श्री/श्रीमती/कुमारी .....

.....पुत्र/पुत्री/पति/पत्नी.....जो कि....

.....रोग से पीड़ित है

जिसके कारण दिनांक .....से ..... तक अपरिहार्य परिथितियों

में इनका उपचार/इलाज मेरे द्वारा किया गया है।

चिकित्सक के हस्ताक्षर
एवं मोहर

Med.-104

CERTIFICATE-B

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

Certificate granted to Mrs./Mr./Miss._____ wife/Son/daughter of Mr._____Employed in the _____.

Part-"A"

(To be signed by the medical officer-in-charge of the case at the hospital)

1 Dr.....hereby certify.

(a) That the patient was admitted to hospital on my advice/the advice of Dr.....
.....(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.

2. The medicines are not stocked in the (Name of hospital).....
.....
.....for supply to private patients and do not include proprictary preparations for which cheaper substances of equal therapeutic value are available, nor preparation which are primarily foods, toilets or disinfectants.

Sr. No.	Name of Medical Store	Bill/Cash Memo No.	Date	Amount
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
			Grant Total:-	

P.T.O.

(c) That the injections administered were/were not for immunising 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 Rs.....
was incurred were necessary and were undertaken on my advice at.....
.....
(Name of the hospital or laboratory)

(f) That I referred the patient to Dr.....for
specialist consultation and that the necessary approval of the .....
.....
(Name of the Chief Administrative Medical office of the State)
as required under the rules was obtained.

Signature and Designation of the
Medical Officer-in-charge of the
Case at the hospital

Place:.....

Date.....

PART-"B"

I certify that the patient has been under treatment at the .....
.....hospital and that the services of the special nurses for which an expenditure of Rs.....was incurred vide bills and vouchers attached were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Place:.....

Date.....

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

COUNTERSIGNED

Place:.....

Date.....

Medical superintendent
..... hospital

I certify that the patient has been under treatment at the .....
.....
hospital and the facilities provided were the minimum which were essential for the patient's treatment.

Place:.....

Date.....

Medical superintendent.
..... Hospital

Note.- Certificates not applicable should be struck off. Certificate (B) is compulsory and must be filled in by Medical Officer in all cases.

परिशिष्ट 'क'

उत्तर प्रदेश सरकार

स्वास्थ्य-पत्रक

[भाग दो, नियम-6(क) देखें]

संख्या-.....

आवेदक के परिवार का प्रमाणित फोटो

कार्यालयाध्यक्ष की मुहर

नाम:- ..... जन्म का दिनांक ..... लिंग.....

पदनाम..... विभाग का नाम .....

तैनाती का स्थान-.....

आवासीय पता-.....

मूल वेतन तथा वेतनमान/पेंशन-.....

नामिनी का नाम-.....

आश्रित पारिवारिक सदस्यों का विवरण-

क्रमांक	नाम	जन्म का दिनांक	आवेदक से सम्बन्ध
1.			
2.			
3.			
4.			
5.			
कुल संख्या			

दिनांक.....

आवेदक के हस्ताक्षर

कार्यालयाध्यक्ष के प्रतिहस्ताक्षर, मुहर सहित।

परिशिष्ट "ग"

(भाग–पांच–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। जिस पर कुल धनराशि रुपया .....व्यय हुआ 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 नकद् पर्ची (कैश मेमो), बीजक (बिल) बाउचर।
3. यह प्रमाणित किया जाता है कि उपर नामित पारिवारिक सदस्य मुझ पर पूर्णतया आश्रित है।

मेरे उपचारार्थ.....के पत्र संख्या .....दिनांक..... द्वारा स्वीकृत रुपया .....के अग्रिम का समायोजन करने के पश्चात् मेरे दावे की प्रतिपूर्ति के लिए यथा आवश्यक कार्यवाही करने की कृपा करें।

दिनांक :–.....

अधिकारी/कर्मचारी का नाम

पद नाम.....

तैनाती का स्थान–.....

.....