CERTIFICATE – B

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

Certificate granted to _____

Self/Wife/Husband/Son/Daughter/Father/Mother of _____

employed in the **National Institute of Epidemiology, (Indian Council of Medical Research), T.N.H.B., Ayappakkam, Chennai – 600 077**

PART - A

(To be signed by the Medical Officer in-Charge of the _____

_____

_____ case of the Hospital)

I, Dr. _____

(Registration No._____) hereby certify :-

01. that the patient was admitted to hospital on the advice of _____

_____ (name of the Medical Officer / on my advice.

02. that the patient has been under treatment at _____

_____ and

that the undermentioned medicines prescribed by me in in this connection were essential for the recovery/prevention of serious determination 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 nor prepartions which are primarily foods, toilets or disinfectants.

03. rged and received Rs._____ (Rupees _____

_____) for administering _____

intra-venous / intra-muscular / subcutaneous injection on _____

_____ **(date to be given)** at my consulting room outside hospital hours.

04. that the injections administered were not/were for immunising or prophylactic purposes.

05. that the patient has been under my 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 nor preparations which are primary foods, toilets or disinfectants.

SL. No.	NAME OF THE MEDICINES	QUANTITY	COST
	TOTAL Rs.		

P.T.O.

06. that the patient is / was suffering from _____ _____ and is / was under my treatment from _____ to _____ .

07. that the patient is / was not given pre-natal or post-natal treatment.

08. that the X-Ray, Laboratory Test etc. for which as expenditure of Rs._____ (Rupees _____) was incurred was necessary and were undertaken on my advice at _____ _____ (Name of the hospital or / Laboratory.

09. that I referred the patient to Dr. _____ for **SPECIALIST** consultation and that the necessary approval of the _____ (Name of the Chief Administrative Officer of the State) as required under the rules was obtained.

10. that the patient did not require / required hospitalisation.

STATION : _____

DATE : _____

SIGNATURE OF AMA / DESIGNATION OF THE MEDICAL OFFICER AND HOSPITAL / DISPENSARY TO WHICH ATTACHED
(SEAL WITH ADDRESS AND REGISTRATION No.)

N.B. : - CERTIFICATES NOT APPLICABLE SHOULD BE STRUCK OFF. CERTIFICATE (5) IS COMPULSORY AND MUST BE FILLED IN BY THE MEDICAL OFFICER IN ALL CASES.