ERNAKULAM DISTRICT POLICE CREDIT CO-OPERATIVE SOCIETY LTD. No. E-877

SHENOY ROAD, KALOOR, KOCHI-682017

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MEDICAL CERTIFICATE

To be filled by the consulting Physician / Surgeon

1. Name and address of the Patient :

2. Age of the Patient :

3. Name of the Hospital treatment was taken :

4. 1) Date of Admission :

   2) Date of Discharge :

5. Hospital Inpatient No. :

6. Hospital O P No. :

7. Are you the regular medical practitioner of the patient ? : Yes / No

8. Describe fully the nature of illness / injury :

9. Describe fully the nature of treatment :

10. Was the patient referred to you by some other Doctor/ Hospital ? : Yes / No
    If yes

    a) Name and address of the Doctor / Hospital :

    b) Diagnosis of the previous Doctor / Hospital :

11. Probable duration of the illness when the patient was first attended by you :

12. Other Remarks :

I certify that the above named patient was treated in the Hospital and the details given above are true to the best of my knowledge.

Signature :

Place :

Name of the Doctor :

Date :

Registration No. :

(Office Seal)

Address :