ESSENTIALITY CERTIFICATES

CERTIFICATE 'A'

(To be completed in the case of Patients who are not Admitted to Hospital for Treatment)

Certificate granted to ……S/o/D//o/W/o. ……..

…….……..of employed in the_I.C.S.S.R. Min. of HRD

I _____ Hereby certify:

(a) That I charged and received Rs._____ for. _____Consultation Consultations on_____ to continue (dates to be given) at my consulting room/at the ICSSR office

(b) That I charged and received Rs._____ for Administering_____

Intravenous/intra-muscular/subcutaneous injections on_____

(dates to be given) at_____my consulting room/the residence of the patient:

(C) That the injections administered were not/were for immersing or prophylactic purposes:

(d) That are patient has been under treatment at: _____ Hospital my consulting room 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 _____and is /Was under my treatment from_____**to Continue**

(e) That the patient is /was suffering from _____and is /Was

Under my treatment from_____

(f) That the patent is /Was not given pre-natal or postnatal treatment:

(Name of Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic values are available nor preparations which are primarily foods, toilets or disinfectants.

Contd - 2

S.No.	Date	Bill No.	Particulars	Amount(in Rs.)-

(g) That the X-ray, laboratory test, etc, for which an expenditure of was incurred was necessary

and were undertaken on my advice at _____(name of the hospital or laboratory)

(g) That I referred that patient to_____ for specialist consultation and that the necessary

(h) approval of the _____(Name of the Chief Administrative Officer of the State) as

required under the rules was obtained:

(i) That the patient did not require/required hospitalization.

Signature of claimant

Signature of AMA/Designation of
Medical Officer and Hospital/
Dispensary to which attached

Date:----------