**To be filled in Hospital/ Doctor’s Letter head**

**Date :**

**TO WHOMSOOVER IT MAY CONCERN**

**This is to certify that Smt./Sri……………………………………………………………………………**

**………………(name of the patient) aged ……years, wife/husband of……………………………**

**Sri/Smt…………………………………………………………………………………………………………**

**(name of ex-employee) is under my treatment for**

**…………..…………………………………………………………………… (name of the ailment).**

**I have prescribed to take the following medicine on domiciliary basis for a period of ……………(Months).**

|  |  |  |
| --- | --- | --- |
| **Sl No** | **Name of the medicine** | **Dosage per day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**He/she is advised to undergo the following one time/ periodical investigation for diagnosis/monitoring of his/her health condition.**

**1.**

**2.**

**3.**

**Advised Review after …………..Months.**

**Signature of the doctor**

**Name of the Doctor**

**Designation**

**Seal with Regn No.**