

## CERTIFICATE

(TO BE FILLED BY THE HOSPITAL/ NURSING HOME/ CLINIC AUTHORITY)

This is to certify that \_\_\_\_\_  
was admitted under my treatment from \_\_\_\_\_ at \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_  
and detail information is as under:-

1. Name of Hospital/ Nursing Home \_\_\_\_\_
2. Whether the same is registered with the local authority or not \_\_\_\_\_
3. If so, Registration No \_\_\_\_\_
4. If not answer the following queries:-
  - A. No of inpatient beds in the Hospital/ Nursing Home: \_\_\_\_\_
  - B. Whether you have fully equipped Operation Theater of your own. Yes/ No
  - C. Whether you have fully qualified Nursing Staff  
in your employment round the clock. Yes/ No
  - D. Whether you have qualified Doctor in Charge round the clock. Yes/ No
5. Date/ Time of Admission \_\_\_\_\_
6. Date/ Time of Discharge \_\_\_\_\_
7. History of present illness with duration of the presenting complaints:
  - (a) What is the exact nature of complaint with which the patient first presented (seen)  
\_\_\_\_\_
  - (b) Since how long he/ she has been suffering for the same  
\_\_\_\_\_
8. Past History of the disease \_\_\_\_\_

Signature of Doctor  
**Or**  
Hospital Authorities  
(Seal of Hospital)