ESSENTIALITY CERTIFICATE

CERTIFICATE 'A'

(To be completed in the case of patient who are not admitted to hospital for treatment)

Certificate granted to Mrs./Mr./Miss……wife/son/daughter of Mr……employed in the ……

I, Dr……hereby certify –

(a) that I charged and received Rs……..for……consultation on……(dates to be given at my consulting room/at the residence of the patient;

(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 immunizing or prophylactic purposes;

(d) that the 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……(name of hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic vale are available nor preparations which are primarily foods, toilets or disinfectants.

	Names of medicines	**Price**
1.	……	……
2.	……	……
3.	……	……
4.	……	……

(e) that the patient is/was suffering from……and is/was under my treatment from……..to……..;

(f) that the patient is/was not given pre-natal or post-natal treatment;

(g) that the X-ray, laboratory test, etc. for which an expenditure of Rs……..was incurred was necessary and were undertaken on my advice at…… (name of the hospital or laboratory);

(h) 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;

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

Signature of AMA/Designation of the Medical Officer and hospital/dispensary to which attached

Dated……..

N.B. – Certificates not applicable should be struck off. Certificate (e) is compulsory and must be filled in by the Medical Officer in all cases.

Gautam Buddha University
Greater Noida
DECLARATION FORM

I hereby declare that the name, age and relationship of my family members for the purpose of medical claims are as given below:

S.No.	Name	Sex/ Age	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Date:-

Signature of Employee

Name:-

Designation –

Countersigned by Registrar