अखिल भारतीय आयुर्विज्ञान संस्थान
ALL INDIA INSTITUTE OF MEDICAL SCIENCES
वीरभद्र रोड, ऋषिकेश-249201
Virbhadra Road, Rishikesh - 249201
उत्तराखण्ड
Uttarakhand

Medical Certificate number-MS/AIIMS/RIS/ 2023 - Date: - / /2023

Medical Certificate

This is to certify that Mr./Mrs./Ms.....

Age ..... yrs male/female, S/o,D/o,W/o.....

R/o ..... having

UHID No. ..... whose signature is attested below is diagnosed for.....

.....

and is under the treatment of Dr. ....., He/ She has been advised

rest w.e.f .....to ..... As per patient's/attendant request, this

certificate is issued for the purposes of.....

Signature of patient.....

Attested by .....

Consultant's Signature with stamp

Name –

Designation –

Department-

This certificate is issued & counter signed only for the purpose as stated above.

Countersigned

Medical Superintendent/Deputy Medical Superintendent

Not for Medico legal Purposes

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Medical Certificate number-MS/AIIMS/RIS/2023- Date: - / /2023

Treatment Certificate

This is to certify that Mr./Mrs/Ms.....

Age ..... male/ female, S/D/W/o.....

R/o ..... having

UHID No. is ..... and signature is attested below is diagnosed for.....

..... and

under the treatment of Dr. .....of .....department. As per

patient's/attendant request this certificate is issued for the purposes of.....

.....

Signature of patient.....

Attested by .....

Consultant's Signature with stamp

Name –

Designation –

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Countersigned

Medical Superintendent/Deputy Medical Superintendent

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Uttarakhand

Medical Certificate number-MS/AIIMS/RIS/2023- Date: - / /2023

Medical Certificate/Fitness Certificate

This is to certify that Mr./Mrs/Ms.....

Age .....male/female, S/D/W/o.....

R/o.....

UHID No. ..... is diagnosed with.....

.....and under the treatment of

Dr..... He/ She has been

advised rest w.e.f.....to .....and is/will fit to resume duty

on..... As per patient/attendant request this certificate is issued for the

purposes of.....

Signature of patient.....

Attested by .....

Consultant's Signature with stamp

Name –

Designation –

This certificate is issued & counter signed only for the purpose as stated above.

Countersigned

Medical Superintendent/Deputy Medical Superintendent

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Medical Certificate number-MS/AIIMS/RIS/2023- Date: - / /2023

To whom so ever it May Concern

This is to certify that Mr./Mrs/Ms ……

Age …….… Yrs., Male/Female, S/D/W/o ……

R/o ……

UHID No……, has been diagnosed with……

…… ,

and requires ……

The estimated expenditure is as follows-

Surgery/Hospitalization	Rs. ……..
Medicines & Consumables	Rs. ……..
Investigations	Rs. ……..
Implant/Others (specify)……..	Rs. ……..
Total	Rs. ……..

Total (In Words) ……..

Signature of Patient ……. Signature & Stamp of Consultant

Attested by …….

Amount to be transferred in bank account details mentioned below:

Bank Name & Branch	**Punjab National Bank, Pashulok Branch**
Account Name	**AIIMS Patient Welfare**
Account No.	**6189000100043543**
IFSC Code	**PUNB0618900**

Counter Signed

Medical Superintendent/Deputy Medical Superintendent

Not for Medico legal Purposes

UNDERTAKING/ घोषणा पत्र

मैं एतदद्वारा घोषणा करता/करती हूँ कि मेरे पिता/माता/भाई/बहन अथवा .....
जिनका नाम ....., यूएचआईडी सं0....., आयु.....
आपके विभाग में वार्ड/ ओपीडी में उपचाराधीन है।

I hereby undertake that my father/mother/brother/ Sister /Son/Daughter or.....namely (Patient Name)....., UHID No....., Age/Sex..... is under treatment in your ward/OPD in your department.

- हमारी आय का कोई श्रोत नहीं है एवं वर्तमान में बीपीएल कार्ड नहीं है।
  We have no source of income and presently we do not have BPL Card.
- मेरे परिवार का कोई भी सदस्य (रक्त संबंध) सरकारी सेवा में/ईसीआई सुविधा प्राप्त/किसी अन्य श्रोत से चिकित्सा प्रतिपूर्ति का पात्र नहीं है।
  None of my family member (in Blood Relation) is in Government Service/ESI covered/ not entitled for medical reimbursement from any other source.
- हम एम्स, ऋषिकेश में सत्यापन के लिए बिल/इन्वॉयस नहीं देंगे।
  We will not submit any medical bills/invoice for verification from AIIMS Rishikesh.
- हम आपके अस्पताल का खर्चा नहीं उठा सकते। और हमारी सालाना आय 2 लाख रूपये से कम है।
  We are unable to bear the treatment expenses in your hospital and our annual income is less then Rs. 2 Lac.
- कृपया हमें गरीबों को दी जाने वाली निःशूल्क इलाज/भोजन की सुविधा प्रदान की जाए।
  Kindly provide us poor free/diet free facility.
- उपरोक्त सूचना मेरी जानकारी के अनुसार सही है।
  The above said information is best of my Knowledge.

रोगी के हस्ताक्षर .....

Signature of Patient/Relative

पूरा नाम/Full Name .....

रोगी के साथ संबंध/Relation with Patient .....

तिथी/Date .....

पूरा पता/Full Address .....

मोबाइल सं0/Mobile No. .....

Countersigned & Stamped by Treating Doctor/HoD