# MEDICAL CERTIFICATE

This is to certify that Mr./Mrs (Name & Address).....

….....is/was under my

treatment for (Name of Illness).....

in this hospital from.....to.....

….....….....as in patient/out patient. He/She was advised

complete rest for….....days w.e.f

….....

(Furnish brief description of the patient's condition on the date of consultation/admission which has necessitated his/her absence in the PSC Examination on ….....)

.....

.....

….....

This certificate is issued to produce before PSC to justify their absence in the exam.

Date : Signature :

Place : Name :

Office Seal : Designation of the Doctor:

Attach Treatment details if any.