# 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 ….....)

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.....
.....

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:

Important :Attach Treatment details.