# MEDICAL CERTIFICATE

Date: ___________

This is to certify that Sri / Smt. / Kum.

_______________________S/O., D/O., M/O.,F/O.W/O.

Sri / Smt. /Kum._________________________________

Working as ______________ in____________________

________________________________________________

Is taking / has taken treatment for_____________________

______________________________________________

During the periods from___________ to________________

He / She requires Prolonged Treatment.

Signature of the Authority.