FORMAT

USE LETTER PAD OF HOSPITAL /DOCTOR

Name and qualification of Doctor **Date**

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Mr……., retired employee of The Federal Bank Ltd now residing at ……. (Full address of retired employee) is under my treatment for……. (Ailment) and he /she needs treatment for life and he requires domiciliary treatment. At present the following medicines with dosages are prescribed for him:-

SL no	Details of Medicine	Dosage
1	Tab	
2	Injection	
3	……	
4	……	

Seal of Hospital **Signature**

Name with Registration Number