

**ESSENTIALITY CERTIFICATE - 'A'**

Certificate granted to \_\_\_\_\_  
wife/husband/son/daughter of \_\_\_\_\_  
employed in the \_\_\_\_\_.

I, Dr. \_\_\_\_\_ hereby certify:-

a) that I charged and received Rs. \_\_\_\_\_ for \_\_\_\_\_ consultation(s) on \_\_\_\_\_ (date(s) to be given) at my consulting room/at the residence of the patient;

b) that I charged and received Rs. \_\_\_\_\_ for administering \_\_\_\_\_ intra-venous/intra-muscular/subcutaneous injections on \_\_\_\_\_ (date(s) to be given) at my consulting room/residence of the patient;

c) that the injections administered were not/were for immunising or prophylactic purposes;

d) that the patient has been under treatment at \_\_\_\_\_ hospital/my consulting room and that the undermentioned medicines prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the \_\_\_\_\_ (name of hospital/dispensary/clinic) for supply to private patients and do not include any proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations, which are primarily foods, toilets or disinfectants;

	Name of medicines	Price	Bill No. & date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

e) that the patient is/was suffering from \_\_\_\_\_ and is/was under my treatment from \_\_\_\_\_ to \_\_\_\_\_;

f) that the patient is/was not given pre-natal or post-natal treatment;

g) that the X-ray, laboratory test etc., for which an expenditure of Rs. \_\_\_\_\_ incurred was necessary and were undertaken on my advice at \_\_\_\_\_ (name of the hospital or laboratory);

h) that I referred the patient to Dr. \_\_\_\_\_ for specialist consultation and that the necessary approval of the \_\_\_\_\_ as required under the rules was obtained;

i) that the patient did not require/required hospitalisation.

Date: \_\_\_\_\_

Signature of AMA/Medical Officer  
with Registration No. & seal