ESSENTIALITY CERTIFICATE

I Certify that Mrs. / Mr. / Miss …… … Wife / Son /Daughter of Mr/Mrs…… employed in the …… has been under my treatment for …….. diseases from ……to …… at ……..Hospital / my consulting room and that the under mentioned medicine prescribed by me in this connection were essential for the recovery / prevention of serious deterioration the condition of the patient . The Medicines are not stocked in the ……Hospital (for supply to patients) and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available or preparations which are primarily foods, toilets of disinfectants.

Name of Medicines	**Price**
…….	……
……	……
……	……

Signature and Designation of Authorized Medical Attendant
Signature of the Medical Officer in charge in the case of the hospital