CERTIFICATE FOR CANDIDATES APPLYING UNDER THE RESERVED CATEGORY FOR CANCER/THALASSEMIA/AIDS

DETAILED ADDRESS OF ISSUING PHYSICIAN AND HOSPITAL
(Mention serial number and date with phone number and address)

This is certify that Ms. / Mr. _____ (Name of the student).
Date of Birth _____C.R./OPD No. _____
D/o / S/o _____ (Mother's / Father's Name), resident of _____
_____
(complete address), is a diagnosed case of _____ (Cancer / Thalassemia / AIDS)*. She/he is undergoing treatment for the same under my care.

_____

(Signature of the Patient)

Attested

_____

(Signature of the Physician)

Name and address of the Physician _____

_____

Stamp of the Physician

*Strike out whichever is not applicable.