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)

Photograph to be attested by the Physician

This is to certify that Ms. / Mr. _____ (Name of the student), Date of Birth: _____ C.R./OPD No. _____ D/o / S/o _____ (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.