

FORM 4
MEDICAL CERTIFICATE FOR LEAVE OR EXTENSION OF LEAVE OR
COMMUTATION OF LEAVE

Signature of the Govt. servant

I, Dr. after careful personal examination
of the case, hereby certify that Sh. /Smt. /Km.
whose signature is given above, is suffering from
and I consider that a period of absence from duty of days with
effect from is absolutely necessary for the restoration of his/her health.

Authorized Medical Attendant
..... **Hospital/Dispensary**
Or other Registered Medical Practitioner

Dated.....