

MEDICAL CERTIFICATE FOR CONTINUOUS MEDICATION

No:

Date:

This is to certify that Mr:.....
, Aged years, MSR No: S/o:
....., residing at
, is under my treatment for [Disease Name].

He She is advised to take the medicines continuously without interruption on a daily basis as part of long-term treatment.

Patient is instructed not to stop or change the dosage without medical advice.

This certificate is issued upon his / her request for official purpose.

Place :.....

Dr. :.....

MBBS, MD/MS - Reg No:

Signature & Seal :.....