

रुग्णालयाचे लेटरहेडवर खालीलप्रमाणे रुग्णालय खर्चाचे प्रमाणपत्र सादर करावे.

ESTIMATE CERTIFICATE

TO WHOM SO EVER IT MAY BE CONCERN

DATE :- / /202

This is to certify that,

Mr./Mrs./Smt.-----Age-----Male/Female-----

Address-----

Is suffering from-----

He / She needs----- surgery at our hospital.

The surgery will be arranged on (Date)-----,(Day)-----

Period of treatment is-----

The approximate expenses / cost of the procedure would be Rs.-----

(Rs. In words -----)

The RTGS /NEFT may please be drawn in favor of-----

**This Patient is BENEFICIARY OF CENTRAL GOVT OR STATE GOVT JEEVANDAI / MAHATAMA JYOTIBA PHULE JEEVANDAI AROGYA YOJNA OR PARALLEL SCHEME
: - YES / NO.**

Dr. Sign. (No for Dr. Sign.)

Dr.Name:-

Reg. No, Degree & Stamp,
Hospital Seal.

THE HOSPITAL ADMINISTRATION WILL BE RESPONSIBLE FOR THE PENAL ACTION

IF ANY DEFECT IS FOUND IN THE UTILITY OF THE GRANT MONEY.

Sign

Hospital Administrator.

(No for Hosp Admin Sign.)

Name :-

Reg no:-

Ph no :-

80)	Shri Markandey Solapur Sahakari Rugnalay	CHARITABLE
	THANE	
81)	Bhakti Vedanta Hospital	CHARITABLE
82)	Cardinal Gracias Memorial Hospital	CHARITABLE
	WARDHA	
83)	Acharya Vinoba Bhave Rural Hospital	CHARITABLE
84)	Mahatma Gandhi Institute Of Medical Science Kasturba Hospital	CHARITABLE