**NAME OF THE HOSPITAL**

Dr. John Killer M.B.B.S., M.S.(Ortho)

751 Victoria 123 Street, South Statue 204

Hometown, US 1234

PH: (207) 808 2014 2014

FAX: (207) 808 2015 2202

S. No. : …………….

Patient Name: ……………………………….. Age: ………… Gender: …………………

Address: ……………………………………………. Date: ……………………………..

Rx

Doctor's Signature: …………………..

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