Application No.: **ILC0011640**

Department of Medical Health & Family Welfare

Goverment of Uttar Pradesh

ILLNESS CERTIFICATE

District Male Hospital, Farrukhabad

Certificate No. : **CILC2410607**

Issuance Date : **27/02/2024**

I, Dr. **RISHIKANT VERMA** hereby certify that I had carefully examined my patient Shri/Smt./Ms. **SHAIPHALI AGARWAL** Son/Daughter/Wife of Shri **MUKESH AGARWAL** on **06/12/2023** having mark of identification **NA** and find that patient is suffering from **LBP WITH B/L LOWER LIMB RADICULOPATHY** and need bed rest for **82** days form **06/12/2023** to **25/02/2024**.

I also certify that before arriving at this decision, I have examined the patient on the basis of medical reports.

Place: **Farrukhabad**
Date: **27/02/2024**
Id Type of Patient : **Aadhaar Card**
Id No. of Patient : **826441754969**

Signature along with official seal
Chief Medical Superintendent
District Male Hospital
Farrukhabad