Application No.: **ILC0012024**

Department of Medical Health & Family Welfare

Goverment of Uttar Pradesh

ILLNESS CERTIFICATE

Dr. RML Hospital, Lucknow

Certificate No. : **CILC2410936**

Issuance Date : **02/07/2024**

I, Dr. **TEST** hereby certify that I had carefully examined my patient Shri/Smt./Ms. **ATUL TRIPATHI** Son/Daughter/Wife of Shri **ATUL TRIPATHI** on **01/06/2024** having mark of identification **NO** and find that patient is suffering from **test** and need bed rest for **31** days form **01/06/2024** to **01/07/2024**.

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

Place: **Lucknow**
Date: **02/07/2024**
Id Type of Patient : **Aadhaar Card**
Id No. of Patient : **1234**
Signature of Patient : **ATUL TRIPATHI**

Signature along with official seal
Chief Medical Superintendent
Dr. RML Hospital
Lucknow