

FORM - IV

MEDICAL CERTIFICATES FOR LEAVE OR EXTENSION OF LEAVE OF  
COMMUTATION OF LEAVE

Signature of the Government Servant .....  
I..... Dr. Preethi ..... after careful personnel examination of  
the case hereby certify that Thiru / Tmt. / Selvi. .... Mrs. Shanthini ..... 22/5 .....

..... whose signature is given above,  
is suffering from ..... MENORRHAGIA ..... and  
I consider that a period of absence from duty ..... 9 days ..... days with effects  
from ..... 6/4/20 ..... to ..... 15/4/20 ..... is absolutely necessary for the  
restoration of his / her health.

STATION: SEYBARKKAM, JOLEN HOSPITAL  
DATE : 15/4/20

JOLEN HOSPITAL PVT. LTD  
No. 1, Bajanai Kovil 2nd Street,  
Sembakkam, Chennai - 600 073  
AUTHORISED MEDICAL /  
ATTENDANT HOSPITAL /  
DISPENSARY OR OTHER  
REGISTERED MEDICAL PRACTITIONER