MONEY RECEIPT		(a) -	
HOSPITAL			
	Date:	Time:	
Patient Name :		Age:	Gender :
	Ward:	Bed No:	
	Paid Amount:		
	For,		Hospital
		,	Authorised Signature
_	Patient Name :	Date:  Patient Name:  Ward:  Paid Amount:	Patient Name:  Age: Ward: Bed No:  Paid Amount:  For,