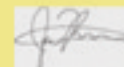


C.Name of attending Clinician:DR.NSUBILI ANGETILE MWANSULE

Qualification:MD

Reg.No:12548

Signature:



D.Patient Certification:

I certify that I received the above named services.

Name:HALIMAJUMA

Mob No:0754272716

Signature:



E.Description of Out/In-patient Management/Any other additional information:

F.Claimant Certification:

I certify that I provide the above names services.

Name:Mrs. Judith

Signature:



Patient should sign the form after completion of service

Before referring patient to other facility, referring facility should be satisfied for the missing item and its alternative within the facility.

Any falsified information may subject you to prosecution in accordance with NHIF Act No.8 of 1999.