

APPLICATION FOR MEDICAL ADVANCE

1.	NAME OF APPLICANT	
2.	DESIGNATION	
3.	BASIC PAY	
4.	AMOUNT OF ADVANCE REQUIRED	
5.	NAME OF THE PATIENT WITH RELATION	
6.	PURPOSE	

DATED

SIGNATURE OF APPLICANT

CERTIFICATE

Certify that _____ of Mr. _____
_____ has _____ Medical advance of
Rs. _____ (Rupees _____) may be
sanctioned for his/her treatment at _____ at (Govt. Hospital).

DATED

MEDICAL OFFICER