FORM – 3

Declaration of fatal diseases

<u>To Whom It May Concern</u>

This is to certify that Mr./ Mrs./ Ms. _____ R/O _____

_____ age _____ years has been thoroughly examined by me that he is suffering from _____

_____ disease(s) and is currently under my conservative care. He/ she requires regular medical follow up and his/ her condition may require emergency medical intervention.

Date _____ (Signature)

Place _____ Name } of the Doctor

Stamp