NAVODAYA VIDYALAYA SAMITI

MEDICAL CERTIFICATE

(To avoid disqualification, please do NOT use abbreviation. Fill it with CAPITAL LETTERS only. Please do not attach any enclosure except where specifically asked for)

Name of the Patient: .....
Relation of the Patient with employee (self / spouse / son / daughter): .....
Date: .....

I, Dr. ..... with Medical Council Registration No. ....., hereby, certify that Shri / Smt / Ms. ..... aged ..... Sex ..... son / daughter / wife / husband of Shri / Smt. ..... (Name of JNV teacher / employee) is suffering from the disease / diseases with the details as follows and that the treatment of this disease is not at all available at this station or its vicinity:

A. In case of Carcinoma (Cancer):

1. Name of Carcinoma with organ (site affected):
2. Date, when it was detected first:
3. Brief History-Pathological Report with reference no. & dates:
4. T N M Classification (if applicable):
5. Evidence in support of uncontrolled growth:
6. Evidence in support of Metastasis:
7. Condition of neighbouring or surrounding structures:
8. Treatment being continued in brief:
9. Full name of Surgery / ies in undertaken with dates:

B. In case of Renal Failure:

1. Name of the disease causing Renal Failure:
2. Evidences in support of Chronic Irreversible Changes:
3. No. of Dialysis done with dates:
4. Single or both kidneys are involved:
5. Any Surgery including Renal transplantation done or not;

C. In case of Loss of Muscle Power (Paralytic Stroke):

1. How many extremities are affected:
2. Grading of Muscle power at present:
3. Grading of Muscle Power at the onset of disease:
4. Duration of Loss of Muscle power:
5. Any recovery after the onset till date:
6. Most direct cause of Loss of Muscle Power:

D. In case of Heart Disease:

1. Name of the surgical procedure undergone (CABG / Angioplasty):
2. Date of Surgical Procedure:
3. Name of Doctor-Surgeon:
4. Name of Hospital:

E. In case of Thalassemia:

1. Name of the disease(with specification-major or minor):
2. Date of first detection:
3. Whether blood transfusion required? **YES / NO**
4. If so, periodically / duration of blood transfusion / replacement required by the patient / Chelation therapy:
5. Blood transfusion done last (DD / MM / YYYY):

F. In case of Parkinson's Disease:

1. Date of detection of the disease:
2. Duration of treatment undergone:
3. Name and designation of treating neurologist:
4. Whether admitted in hospital and if so, details thereof:
5. Progressiveness of the disease-please specify:
   (to be certified by a neurologist)

G. In case of Motor-neuron disease:

1. Date of detection of disease:
2. Duration of treatment undergone:
3. Name and designation of treating neurologist:
4. Result of EMG test report and MRI:
5. Grading of muscle power at present:

Signature of the signing Authority
Name:
Name of the Deptt:
Name & Signature of the patient **Name of the Hospital**
Place:
Date:
Seal:

Name of the Patient: .....

Relation with the Employee (Self / Spouse / Son / Daughter): .....

(If the certifying doctor is below the rank of Civil Surgeon or equivalent, it should be countersigned by a doctor of the rank of Civil Surgeon or equivalent).

Counter signature of the CMO / CMS / Civil Surgeon

Name:

Date:

Seal:

Sign. of the Principal (for JNV Staff) / the Director, NLI (for NLI Staff) / the Deputy Commissioner (For HQ/RO staff)

Name:

Date:

Seal:

Principal (in case of JNV employees) / the Director, NLI (in case of NLI employees) and the DC (in case of RO / HQ employees) should sign the certificate having been satisfied with all the clauses of medical certificate being clearly mentioned and endorsed in context of the provisions of transfer policy and guidelines.

Note : Medical Certificate, without having countersignature / endorsement of the Principal / DC / Director of the concerned establishment, will be treated as null and void.