# CERTIFICATE FOR CANDIDATES APPLYING UNDER THE RESERVED CATEGORY FOR CANCER / THALASSEMIA / AIDS

**DETAILED ADDRESS OF ISSUING PHYSICIAN AND HOSPITAL**
**(Mention serial number and date with phone number and address)**

This is to certify that Ms. / Mr. ________________________________________ (Name of the student),

Date of Birth: _____________________ C.R./OPD No.________________________________________

D/o / S/o ______________________________________________ (Mother's / Father's Name), resident

of__________________________________________________________________________________

____________________________________________________________________________________

(complete address), is a diagnosed case of __________________________ (Cancer / Thalassemia / AIDS)*. She/he is undergoing treatment for the same under my care.

__________________________

(Signature of the Patient)

Attested

__________________________

(Signature of the Physician)

Name and address of the Physician ____________________________

_________________________________________________________

Stamp of the Physician

*Strike out whichever is not applicable.