



**ICAR-CENTRAL ISLAND AGRICULTURAL
RESEARCH INSTITUTE
PORT BLAIR-744105**



MEDICAL CERTIFICATE

Signature of Applicant

I, Dr. after careful personal examination of the case hereby certify that Dr. /Shri /Smt. /Ms.(name & designation of applicant) of the Office of the whose signature is given above is suffering from and, therefore, I consider, that a period of absence from duty fromto with effect from is absolutely necessary for the restoration of his/her health.

Place

Signature of Government Medical
Officer /Civil Surgeon / Staff
Surgeon/Authorized Medical
Attendant/Registered Medical
Practitioner along with official seal

Date:Registration No. _____

