

Utilization Certificate

This is to certify that..... (Name of Medicines, quantity, dose, frequency)

..... Issued to..... (Name & Token No of

Patient /Name of Dispensary) issued on..... (Date of issue)

has been utilized /will be utilized by(Date)..... If required empty strips/vials will be

submitted.

Signature of Patient

Signature of the Specialist/ CMO

Token No: -

Date:-

Address & Telephone No

Stamp

Counter Signature of CMO I/C WC with Stamp