

HOSPITAL ADMISSION CERTIFICATE

Certificate No.:	<input type="text"/>
Patient Name:	<input type="text"/>
Date of Birth:	<input type="text"/>
Gender:	<input type="text"/>
Address:	<input type="text"/>
Admission Date:	<input type="text"/>
Ward/Room No.:	<input type="text"/>
Reason for Admission:	<input type="text"/>
Consultant Doctor:	<input type="text"/>
Remarks:	<input type="text"/>
Date:	<input type="text"/>
Doctor's Signature:	<input type="text"/>