DENTAL CERTIFICATE

Dental Hospital, Faculty of Dentistry
Mahidol University
6 Yothi Street, Rajthevi, Bangkok 10400

Date..

Dentist's name..Dental registration No...................

Patient's name ....Age.................yr. HN....................

Address..

was examined on (day/ month/ year)..

By the undersigned and diagnosed as having...

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Treatment and/or recommendation..

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This dental certificate in correspondent with the receipt number.............................date...............

is intended to be used for proper reimbursement

Signature...

(..)

Dentist/Doctor