SCHEDULE-VII

(see sub-regulation (3) of regulation 23)

ISTEHQAQ CERTIFICATE
(FOR TREATMENT OF A MUSTAHIQ PERSON)

PART-I
TO BE FILLED IN BY THE LOCAL ZAKAT COMMITTEE CONCERNED

1. Local Zakat Committee: ……Code NO……..… Date: ……..
2. It is certified that Mr./Mrs. …… S/o, D/o, W/o: …… CNIC: …….. and as per CNIC, his/her permanent / temporary resident is…….
3. He/she is suffering from…….
4. It is further certified that he/she is Mustahiq-e-Zakat and eligible for Healthcare Program.
5. She/he has been registered at Serial No .....of this Local Zakat Committee's record.
6. It has been verified that he/she has no sufficient source of income to meet the expenditure of the illness.
7. It has been verified that he/she is not receiving any assistance for medical treatment from other sources i.e Pakistan Bait-ul-Mal or any other government or reimbursement source.

Signature with Stamp
Chairman Local Committee

PART-II
(TO BE FILLED BY THE DISTRICT COMMITTEE CONCERNED)

Form is complete, signature of Chairman Local Committee is verified and patient is referred to; District Level Hospital _____ vide Dispatch No._____ dated _____.

OR

Provincial Level Hospital _____ with the certificate that credential of the patient have been uploaded through District Portal and the case has been registered vide dispatch No._____
dated _____.

Signature with Stamp Chairman
District Committee / District Zakat Officer

PART-III
(FOR THE USE OF THE HOSPITAL)

It is certified that the patient is not being treated in this hospital for this disease through any other resources, such as the Sehat Card, Pakistan Bait-ul-Maal, or any other government or reimbursement source. Therefore, he/she is being provided assistance from Zakat funds.

Head of the Hospital/Incharge Zakat Cell

SCHEDULE-X
(See Regulation 42)

COST ESTIMATE CERTIFICATE OF THE SPECIAL HEALTHCARE PROGRAM

Hospital's Nam: _____ Dated: _____

1. Patient's Name: _____ Age_____ Sex (Male / Female)
2. Father's /Husband's Name: _____
3. CNIC No. _____Mobile No. _____
4. Home Address: _____
5. Reg/File No. _____ Indoor ☐ Outdoor ☐
6. Disease Diagnosed _____ Treatment Duration _____

S.No.	Title: Medicine/ Disposable / Implant / Investigation	Potency	Dosage	Rate per unit	Net Cost
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					
xi.					
xii.					
				Total Cost:	
Deduction of Sehat Sahulat Programme balance (if any)					
Deduction of Pakistan Bait Ul Mal balance (if any)					
Deduction of other sources of funding (if any)					
Net Amount Required from Zakat Special Healthcare Program					

- The treatment expenditure exceeds Rs. 50,000/-

Recommendation of the Health Welfare Committee (HWC)		
Designation	**Name**	**Signature and Stamp**
Head of the Department / Consultant		
Pharmacist		
In charge Zakat Cell of the hospital		
Medical Superintendent / Hospital Director		
Chairman DZC/DZO		