|  |
| --- |
| **C:\Users\VPN-2\Desktop\images.jpg** |

**MEDICIAL CERTIFICATE**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**I the ungersigned Doctor in Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Full Name)**

**Certify that I have examined the blood test result and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ test of**

**Mr. / Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Full Name)**

**Nationality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Place of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Martial status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Residing At:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have found him/her as described below:**

|  |  |  |
| --- | --- | --- |
| **Name of illness** | **Free of following**  **illness** | **Suffering from**  **following illness** |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **4.** |  |  |
| **5.** |  |  |

**Issued at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**