

Medical Certificate

I, the undersigned Doctor in medicine, (full name).....

.....

Certify that I have examined the blood test results and chest X-rays of Mr/Mrs.

(full name).....

.....

Nationality

Passport No.....

Date and place of birth.....

Residing at

And have found him /her (please check the appropriate box):

	Free of the following illness	Afflicted with the following illness
HIV/AIDS		
Hepatitis		
Band C		
Tuberculosis		
Syphilis		

Issued at on

Signature of doctor

Stamp of doctor's office.....