

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 B and C		
Tuberculosis		
Syphilis		

Issued at on

Signature of doctor

Stamp of doctor's office.