



**MEDICAL FITNESS CERTIFICATE**

(To be signed by a registered medical practitioner holding a degree not below that of MD)

**(TO BE SUBMITTED WITH THE APPLICATION FILE)**

**THE PATIENT:**

(Please provide these data exactly as they appear in passport and/or ID card.)

**First / given name:** .....

**Family name /surname:** .....

**Permanent home address:** .....

**Date (dd/mm/yyyy) and place of birth:** .....

I, Dr. ....

(address: .....

.....

after examining the patient, certify that he/she is free from infectious diseases, and has no disease or physical or mental infirmity unfitting him/her now or likely to unfit him/her for registration and enrollment as a future student at the faculty of medicine / dental medicine/ pharmacy.

Any chronic diseases the patient is being treated for: .....

Remarks / Special recommendations / Special needs: .....

.....

.....

PLACE AND DATE: .....

.....  
DOCTORS' SIGNATURE AND  
SEAL

**Declaration by the patient / candidate:** I declare that all the statements above are true and correct to the best of my knowledge. I fully understand that I am responsible for the accuracy of all statements given.

PLACE AND DATE: .....

.....  
SIGNATURE OF THE  
PATIENT