

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:

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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