

MEDICAL CERTIFICATE

Date

I, Name a medical doctor holding medical license No.

..... Issued on dayMonth Year

have examined on date..... and have

(name)

foundfree from the following diseases:

(name)

1. LEPROSY
2. TUBERCULOSIS (T.B.)
3. ELEPHANTIASIS
4. DRUG ADDITION
5. THIRD STEP OF SYPHILIS

..... is in good physical and mental health free from
(name)

any defect.

(Signature) M.D.

(.....)

Name (in print)

THIS SECTION FOR NOTARY PUBLIC USE ONLY

Subscribed and sworn to and before me, a Notary Public in and for _____
County, State of _____ this _____ day
of _____ Year _____

Seal & Signature _____

(_____)

Notary Public

My commission expires: _____