MEDICAL CERTIFICATE

Date.....

Name.....(Medical Doctor)

Holding medical license No.....issued on date.....month.....year.....

Have examined (name of patient).....

born on, day.....month.....year.....on date.....and have found

(name of patient).....free of the following diseases

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

(name of patient)……is in good physical and mental health.

Signature…….MD

(……..)
(name in print)

Address……..

……...

Tel. (…….)……