GENERAL MEDICAL CERTIFICATE

LEGAL NAME *(WRITE NAME EXACTLY AS IT APPEARS ON OFFICIAL DOCUMENTS)*

FIRST/GIVEN NAME: _____

FAMILY/SURNAME: _____

PERMANENT (HOME COUNTRY) **ADDRESS**:

_____

_____

PLACE AND DATE OF BIRTH: _____
(*MM/DD/YYYY*)

The individual mentioned above is at present free from signs and symptoms of infection. It is hereby certified that he/she is physically and mentally fit to pursue university studies in the field of health sciences.

Remarks*:

_____

_____

_____

**Please also indicate any special needs or diagnosed learning disability that would affect academic studies.*

NAME OF THE DOCTOR: _____

ADDRESS OF THE PRACTICE: _____

DATE: _____
(*MM/DD/YYYY*)

SIGNATURE AND STAMP OF REGISTERED MEDICAL DOCTOR: _____