

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:

NAME OF THE DOCTOR: _____

ADDRESS OF THE PRACTICE: _____

DATE: _____
(MM/DD/YYYY)

SIGNATURE AND STAMP OF REGISTERED MEDICAL DOCTOR: _____