**CERTIFICATE OF MEDICAL FITNESS**

Issuance Date: \_\_\_\_\_\_\_\_\_\_\_

This is to certify that Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of age \_\_\_\_\_\_\_\_, presently residing at  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ whose signature is given below.

Based on the examination, I certify that he/she is in good mental and physical health condition including normal eyesight, and is free from any physical defects.

Signature of the Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name & signature of the Medical Officer
with seal and registration number.