MEDICAL FITNESS CERTIFICATE

(To be signed by a registered medical practitioner holding a degree not below that of MD)

(TO BE SUBMITTED WITH THE APPLICATION)

THE PATIENT:

(Please provide these data exactly as they appear in passport and/or ID card.)

First / given name: .....

Family name / surname: .....

Permanent home address: .....

Date (dd/mm/yyyy) and place of birth: .....

I, Dr. …… (address: ……

……) after examining the patient, certify that he/she is free from infectious diseases, and has no disease or physical or mental infirmity unfitting him/her now or likely to unfit him/her in the future for participation as a student in a training program for medicine / dentistry / pharmacy.

Any chronic diseases the patient is being treated for: .....

Remarks / Special recommendations / Special needs: .....

.....

.....

PLACE AND DATE: .....

…….

DOCTORS' SIGNATURE AND SEAL

Declaration by the patient / candidate: I declare that all the statements above are true and correct to the best of my knowledge. I fully understand that I am responsible for the accuracy of all statements given.

PLACE AND DATE: .....

…….

SIGNATURE OF THE PATIENT