

## **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