GENERAL MEDICAL CERTIFICATE

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

FIRST/GIVEN NAME: ____

FAMILY/SURNAME: ____

PERMANENT (HOME COUNTRY) **ADDRESS**:

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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*:

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**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: ______________________