**Health Certificate**

 Date……….. Month………… Year………….

**Part I Information of Applicant for Health Certificate**

I (Mr. / Mrs. / Ms.) …………………………………………………………………………….

Identification card No.

Contact address……………………………………………………………………………………….

Telephone / Mobile phone……………………………………………………………………………

have applied for the certificate of my health with the following details

 No Yes

1. Personal ailment

(specify)...............................................................................................

1. Accident and surgery

(specify)...............................................................................................

1. Hospitalization

(specify)...............................................................................................

1. Other important health history………………………………………….............................

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Signature**……………………………… (Parents / guardians can sign on behalf of a child )

**Part II Physician’s information**

 I, Dr. ………………………………………. License No…………………………………………….

Medical Profession Practice Place………………………………….Address…………………………

…………………………………………………… Telephone/mobile phone……………………….. have already conducted a physical examination of Mr. /Mrs. /Ms. ........................................................

……………………………………………………with the following health condition details

Weight……kg. Height …… cm Blood pressure…… mmHg Pulse …….. time / minute. General health conditions are □ normal □ abnormal (specify)………………………………

This is to certify that the person is not the disabled who cannot perform his/her duty. There are no traces of mental infirmity, mental retardation, substance dependence, or chronic alcoholism. Also there are no symptoms of the following diseases:

1. Leprosy at the contagious stage or full – blown stage which might cause discomfort to others
2. Tuberculosis at a threatening stage
3. Elephantiasis at a threatening stage
4. Other diseases……………………………………………………………………………………….

…………………………………………………………………………………………………........

Physician’s summary and suggestions…………………………………………………………..

…………………………………………………………………………………………………………..

 **Signature**……………………………………………

 (of the physician who conducts physical examination and issues the health certificate)

**Remarks**

1. The date must be the same date in part I and part II
2. License No. refers to the number of the Medical Professional Practice License
3. This is to indicate how perfect the person’s health is. This certificate is considered to be the primary diagnosis
4. This health certificate expires one month after the physical examination.