DATE: / /

HEALTH CERTIFICATE

To Whom It May Concern:

|  |  |  |
| --- | --- | --- |
| Name: |  | |
| Date of Birth: | / / | Age: |
| Sex: |  | |
| Address: |  | |

This is to certify that the above person has No abnormalities on following physical examination and laboratory examinations including:

Chest X-ray:

ECG:

Blood Chemistry:

Urinalysis:

Physician’s Name:

Signature: