

## **MEDICAL CERTIFICATE**

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ Weight: \_\_\_\_\_

Vision: \_\_\_\_\_

Blood Group: \_\_\_\_\_

Dissabilities: \_\_\_\_\_

Fitness :    ☐ Below mark            ☐ Good            ☐ Excellent

Issuing Office: \_\_\_\_\_

Issuing Authority

(Signature and Stamp)