

SOUTHWESTERN UNIVERSITY

PHINMA

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Masters in Public Management - Health Systems Development

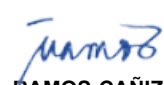
NAME:
ADDRESS:

DATE:
AGE/SEX:

MEDICAL CERTIFICATE

This is to certify that the patient, whose name appears above, has submitted himself/herself to the University Clinic for HCW Risk Assessment and **Online Teleconsultation**.

Remarks:


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