

MEDICAL FITNESS CERTIFICATE

(To be signed by a registered medical practitioner holding a degree not below that of MD)

(TO BE SUBMITTED WITH THE APPLICATION FILE)

THE PATIENT:

(Please provide these data exactly as they appear in passport and/or ID card.)

First / given name:	
Family name /surname:	
Permanent home address:	
Date (dd/mm/yyyy) and place of birth:	
I, Dr(address:	
after examining the patient, certify that he/she is free from	m infectious diseases, and has no
disease or physical or mental infirmity unfitting him/her r	now or likely to unfit him/her for
registration and enrollment as a future student at the facul	lty of medicine / dental medicine/
pharmacy.	
Any chronic diseases the patient is being treated for:	
Remarks / Special recommendations / Special needs:	
PLACE AND DATE:	
	DOCTORS' SIGNATURE AND SEAL

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Declaration by the patient / candidate: I declare that all the statements above are true and correct to
the best of my knowledge. I fully understand that I am responsible for the accuracy of all statements
given.
PLACE AND DATE:
SIGNATURE OF THE PATIENT