Medical Certificate

Name: Male / Female

Date of birth (Month/Day/Year): ( years old)

Nationality:

I hereby state and verify that the person named above is unrelated to (not suffering from) any of following matters / conditions:

1. Blindness, deafness, or inability to speak
2. Suffering from a mental condition
3. Addicted to narcotics, marijuana, or opium

Date (Month/Day/Year):

Institution Name:

Address:

Name of the physician: Seal