

# Medical Certificate

Name of the patient:

..... , .....  m ♂  f ♀ .....  
Last Name(s) First Name(s) gender born (dd/mm/yyyy)

The undersigned doctor, legally authorized to carry out his/her profession, having exercised physical examination on the above mentioned patient attests:

- There are no symptoms of any organic/infectious/contagious disease.
- The patient does not suffer any chronic disease that would constrict him physically.
- Observations/diseases/comments:

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If known, Blood Type: .....

If known, Rhesus Factor: .....

*Seal and/or professional license number:*

Date: .....

Doctor's name: .....

Doctor's signature: .....