Medical Certificate

This is to certify that **Mr./ Ms./Mrs**. _____ **Son/ Daughter** of ____

_____ **Age** _____ Years of **Village / Town** _____

P.O _____**District** _____ **State** _____ is free from defective vision, deafness and other health issues that are likely to interfere with the effectiveness of their work. **He / She** is in good health and is able to perform to their full capacities without any hindrances.

This certificate is provided to **him / her** for the purpose of _____.

Signature of the Applicant _____

Name of the Medical Officer _____

Registration Number _____

Date _____

Seal of the Medical Institution _____

Signature of Medical Officer _____