

Medical Certificate

Name of official _____

Caste or race _____

Father's Name _____

Residence _____

Date of Birth _____

Exact height by measurement _____

Personal Mark of Identification _____

Signature of the official _____

Signature of head of office _____

Seal of office _____

I do hereby certify that I have examined **Mr./Ms./Mrs.** _____
a candidate for employment in the office of the

And can not discover that he had any disease communicable or other constitutional affection or
bodily infirmity except _____.

I do not consider this as disqualification for employment in the office of the _____
_____. **His/ Her** age according to his own statement _____ years and
by appearance about years _____.

Date _____

Medical Superintendent _____

Hospital Name _____