MEDICAL CERTIFICATE

Date ...........................................

I, Name ................................................... a medical doctor holding medical license No. ...................................................

Issued on day ......................... Month ............................ Year ............................

have examined ............................................ on date ............................................ and have

(name)

found ............................................ free from the following diseases:

(name)

1. LEPROSY
2. TUBERCULOSIS (T.B.)
3. ELEPHANTIASIS
4. DRUG ADDICTION
5. THIRD STEP OF SYPHILIS

............................................ is in good physical and mental health free from

(name)

any defect.

(Signature) ..................................................... M.D.

.....................................................

Name (in print)

THIS SECTION FOR NOTARY PUBLIC USE ONLY

Subscribed and sworn to and before me, a Notary Public in and for __________________________

County, State of __________________________ this _____ day

of __________________ Year __________________

Seal & Signature .................................

.....................................................

Notary Public

My commission expires: __________________________