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 ADDITION
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: _______________________