MEDICAL CERTIFICATE OF HEPATITIS/CHICKENPOX/ MMR/ COVID- 19 / VACCINATION

I, Dr. .....Registration No.....

certify that I have administered the HBS AG/MMR/ CHICKENPOX/ COVID-19 Vaccines to the candidate whose particulars given below, on ……./……./2024

1. Name of the Candidate :
2. Gender :
3. Age :
4. Identification marks :1.

2.

SIGNATURE OF THE APPLICANT

SIGNATURE OF MEDICAL OFFICER

NAME AND DESIGNATION

Place:

Date:

Office Seal