PHYSICAL FITNESS & MEDICAL CERTIFICATE OF HEPATITIS/CHICKENPOX/ MMR/ COVID- 19 / VACCINATION

I, Dr……, Registration No……, hereby certify that I have administered the **Hepatitis/ MMR/ Chickenpox/ COVID-19** vaccines to Mr/Ms ……, Gender…… Age…… on ……../…../…….. The identification marks of the candidate are: (1) ……. (2) ……..

I further certify that, after careful personal examination, the above candidate has been found to be physically fit to undergo professional education. The candidate's physical measurements are as follows: Height: ……cm, Weight: ……kg, Chest: ……cm, Vision: ……

Signature of Candidate:

Name of Doctor:

Reg. No.:

Designation:

Place:

Date:

Office Seal