MINISTRY OF HEALTH

MEDICAL AND PUBLIC HEALTH SERVICES

MEDICAL CERTIFICATE

THIS IS TO CERTIFY THAT

FULL NAME: .....

(AS IT IS WRITTEN IN THE PASSPORT)

NATIONALITY .....

DATE OF BIRTH .....

PASSPORT NUMBER ..... M.P.No .....

NAME OF EMPLOYER / ..... Tel No .....

PRIVATE EMPLOYMENT AGENCY ..... Tel No .....

The above named person IS NOT a CARRIER / DOES NOT SUFFER from:

- TUBERCULOSIS
- HEPATITIS B
- HEPATITIS C
- HIV/AIDS
- SYPHILIS

DOCTOR'S SIGNATURE: .....

DOCTOR'S NAME .....

HEALTH CENTRE STAMP

DATE ..... / ..... / .....

Note: In case of positive results cross out the aproopriate NOT / DOES NOT and CIRCLE the relevant disease(s) and forward to the Ministry of Health FAX: 22771496