INSTITUTE OF HOTEL MANAGEMENT CATERING TECHNOLOGY & APPLIED NUTRITION, JYOTISAR, KURUKSHETRA-136119

MEDICAL CERTIFICATE

To be filled by the candidate's Medical Practitioner

Name of the candidate _____

Son/Daughter of _____

Blood Group with RH factor _____

Identification Mark _____

Address _____

_____

_____

MEDICAL HISTORY

Certified that I have examined Mr / Ms _____ whose signature is given below, in regard to following infectious diseases:

a) Skin disease _____

b) Psoriasis follicle c) _____

Tuberculosis _____

d) Trachoma _____

e) Venereal disease f) _____

Epilepsy _____

g) Leukaemia _____

Finding _____

_____

Signature of the candidate

Medical Practitioner _____

Date _____

Place _____

_____