

Temperature \_\_\_\_\_ °F at(Time) \_\_\_\_\_ on(Date) \_\_\_\_\_

**Certificate of Fitness by Health Team ( Form 'F' )**

Name of the Person \_\_\_\_\_ S/o,D/o \_\_\_\_\_

Mobile Number \_\_\_\_\_

Screened on date \_\_\_\_\_

**ENT Examination \_\_\_\_\_ Name/Signature of Doctor with stamp**

**Chest & TB Examination \_\_\_\_\_ Name/Signature of Doctor with stamp**

**X-Ray Chest – Film+ Report \_\_\_\_\_ Name/Signature of Doctor with stamp  
(PA view)**

**CBC Result ( Attach)**

**Person has been screened and found asymptomatic and is allowed to travel.**

**Signature of Doctor \_\_\_\_\_**

**Name of Doctor \_\_\_\_\_**

**Medical Council Registration No \_\_\_\_\_**

**Date \_\_\_\_\_**

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