TO WHOMSOEVER IT MAY CONCERN

I Dr._____have clinically examined Mr / Ms _____
Age_____(Years) date of birth_____and certify that his / Her:

Height : _____cms

Weight: _____Kgs

Body Mass Index (BMI): _____

Colour Vision: _____

Vision Near Vision: _____

Distant Vision: _____

Whether corrected by Contact lenses: Yes / No

Correction :

Signature of the Doctor

Name of the Doctor

Registration no:

Stamp

Date of issuance :

Place of issuance :