## Physical Certificate Form PDF

**Patient Details**  
  
**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Evaluation  
  
Chronic Conditions: □ Yes □ No  
Medications: □ Yes □ No  
If yes, list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Examination Results**

| **Measurement** | **Result** | **Normal Range** | **Notes** |
| --- | --- | --- | --- |
| **Height** |  |  |  |
| **Weight** |  |  |  |
| **BMI** |  |  |  |
| **Blood Pressure** |  |  |  |
| **Vision Test** |  |  | **Left Eye / Right Eye** |

**Physician’s Declaration**  
I, the undersigned, confirm that the medical information is correct and the patient has been evaluated as per standard medical procedures.  
  
**Physician's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**