## 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.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**