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

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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.: _____

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