FACILITY NAME AND LOGO

Health Fitness Certificate

Personal details	
Name	
CPR number	
License number	
Profession	☐ Physician: (specify specialty) ---------- ☐ Dentist ☐ Nurse (specify specialty) ---------- ☐ Pharmacist ☐ Allied Health Professional
Facility Name	

Tests	**Positive**	**Negative**	**Examination**	**Findings**
HIV-1/HIV-2			Blood pressure	
HbsAg			Random Blood Sugar	
HCV				

*TB Screening	Positive	Negative
PPD reading (Number is needed) Or IGRA		
Chest X-ray (if required)		

Physical Examination	**Normal**	**Abnormal**
General		
Chest		
Heart		
Abdomen		
Other (Specify) ----------		
Referral **If Required to be referred to :**	☐ Required	☐ Not Required

*TB screening as per guideline

Physical Examination	Normal	Abnormal
_____		

Vaccination		
** Vaccination	☐ Completed	☐ Not completed
Comments ----------		

☐ I declare that there are no health problems or illnesses (physical or mental) which may in an way restrict the professional's ability to practice safely as a health professional

☐ I declare that the information given in this certificate is complete and correct

Examination performed by	
Name	
License Number	
Category	
Date	
Signature	

**Vaccination according to Guideline for Vaccination of health care workers (MOH)