Date: / /

HEALTH CERTIFICATE

To Whom It May Concern:

Name:

Date of Birth:

Sex:

Nationality:

Address:

This is to certify that the above person has NO Tuberculosis because of the following examinations’ results;

Chest X-ray: Date: / /

QantiFERON-TB test (QRT): Date: / /

Physician’s Name:

Signature:

Physician’s address, phone and fax :