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 :