**Healthcare Provider Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Facility Name: | [Healthcare Facility Name] | Address: | [Street, City, State, Zip Code] |
| Phone Number: | [Contact Number] | Email: | [Email Address] |

**Patient’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: | [Patient’s Full Name] | Date of Birth: | [MM/DD/YYYY] |
| Gender: | [Gender] | Address: | [Street, City, State, Zip Code] |

**Certificate Statement**

This is to certify that [Patient’s Full Name], born on [Date of Birth], has undergone a health evaluation on [Date of Examination]. Based on the medical examination and assessment, it is determined that the individual is in satisfactory health and is free from any contagious or acute medical conditions that could prevent them from safely participating in routine activities, employment, or travel.

The individual does not exhibit symptoms of any conditions that would affect their ability to carry out regular activities and is fit for [specific purpose, e.g., employment, travel, participation in sports].

**Examining Physician’s Statement**

I, the undersigned, have conducted a health assessment of the above-named individual. The evaluation includes:

|  |  |  |  |
| --- | --- | --- | --- |
| Vital Signs Check (e.g., Blood Pressure, Pulse) |  | Basic Physical Examination |  |
| Review of Medical History |  | | |

The individual’s overall health condition is satisfactory, and no significant health concerns were identified during this examination.

|  |  |  |  |
| --- | --- | --- | --- |
| Physician's Signature: |  | | |
| Physician’s Full Name: | [Physician’s Full Name] | Medical License Number: | [License Number] |
| Date: | [MM/DD/YYYY] | Stamp/Seal of Medical Facility: |  |

Additional Notes: this certificate is issued based on the health status of the individual at the time of examination. It is valid for a limited period or as required by specific regulations.