MEDICAL CERTIFICATE

The undersigned Doctor in medicine (full name)

…….

Certifies that he/she has examined this day Mr./Mrs./Ms./Miss (full name)

……

Nationality:

……..……

Date and place of birth:

……..……

Residing at:

……

And has found him/her free of one of the following illnesses as mentioned in the annex of the law of 15/12/1980 and representing a danger for public health :

1. Illnesses requiring quarantine as stated by the international health regulation n°2 dated 25 May 1951, of the World Health Organization;
2. Pulmonary tuberculosis, active or progressive ;
3. Other contagious or transmittable diseases by infection or parasites if they are subject in the host country to provisions of protection of the nationals

Issued at …… on ……..

Signature of doctor ……

Stamp of doctor's office. ……..

If applicable,
Visa of the Embassy, Consulate general or Consulate (Seal)

At ……, on ……..