

**CERTIFICATE OF MEDICAL FITNESS**

This is to certify that,

I have conducted clinical examination of Dr.....  
who is desirous of admission to Dental Postgraduate Courses.

He/she has **not given** any personal history of any disease incapacitating him/her to undergo the professional course.

Also, on clinical examination it has been found that he/she is **medically fit** to undergo the Dental Postgraduate course.

The notable findings during clinical examination of Dr.  
..... are as under:

- (1) Absence of any incapacitating and /or progressive systematic disease/disorder / condition
- (2) Absence of any disability of upper limb/s
- (3) Absence of any major visual/auditory disability
- (4) Absence of psychosis/neurosis/mental retardation
- (5) Ability to maintain erect posture
- (6) Reasonable manual dexterity

Name of Registered Medical Practitioner: \_\_\_\_\_

Registration No.: \_\_\_\_\_

Address of the Registered Medical Practitioner:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Seal of Registered Medical Practitioner