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**State Polytechnic of Sriwijaya**

**CERTIFICATE OF HEALTH**

TO BE COMPLETED BY PHYCISTS/MEDICAL DOCTOR:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Male \_\_\_\_ Female

Pace/date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Visual Acuity  Without glasses Right Left  With glass or  Contact lenses Right Left  Color blindness : yes : / No : Physical handicap : yes : / No : Please mention : | Auditory Acuity |
| Chest X-ray  Date Film Number  Routine size  Small size  (Please check) Normal  Tuberculosis  Other disease  ( ) | Any disease or disorder else |
| I hereby certify that the applicant’s health conditions are as above described.  Signature Date (Full Name)  Hospital/Clinic  Address | |