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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 AcuityWithout glasses Right LeftWith glass orContact lenses Right LeftColor blindness : yes : / No : Physical handicap : yes : / No : Please mention : | Auditory Acuity |
| Chest X-rayDate 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  |