

TO WHOMSOEVER IT MAY CONCERN

I Dr. _____ have clinically examined Mr / Ms _____
Age _____ (Years) date of birth _____ and certify that his / Her:

Height : _____ cms

Weight: _____ Kgs

Body Mass Index (BMI): _____

Colour Vision: _____

Vision Near Vision: _____

 Distant Vision: _____

 Whether corrected by Contact lenses: Yes / No

 Correction :

Signature of the Doctor

Name of the Doctor

Registration no:

Stamp

Date of issuance :