Medical Certificate For Travel

Certificate No.: [Certificate Number]

Date Issued: [Date]

TO WHOM IT MAY CONCERN:

This is to certify that:

Name of Passenger: [Full Name]

Date of Birth: [DOB]

Passport Number: [Passport Number]

Address: [Full Address]

has been examined in our facility and found to be in suitable health condition for travel. Detailed findings are as follows:

Medical Examination Details:

- **Date of Examination:** [Date of Examination]
- **Results of COVID-19 Test (if applicable):** Negative/Positive*
- **Other Relevant Tests Performed:** [List any other relevant tests performed if applicable]
- **Overall Health Status:** [State general health condition, e.g., stable, fit to travel, etc.]

Special Considerations or Recommendations:

- [List any recommendations for travel or specific care requirements during travel, if any.]

This certificate is issued upon the request of the above-named passenger for the purpose of travel to [Destination Country/City], specifically for their upcoming flight on [Flight Date], with [Airline Name], Flight Number [Flight Number].

Please note that this medical certification is valid until [Validity Date], and it verifies only the health condition of the individual as assessed on the date of examination.

For any further information or verification, do not hesitate to contact our medical facility.

Issuing Doctor/Physician:

- **Name:** [Doctor's Full Name]
- **Qualifications:** [Qualifications]
- **License No.:** [License Number]
- **Contact Information:** [Phone Number], [Email Address]
- **Signature:** _____
- **Stamp of Medical Institution**