

Health Clearance Certificate

Date:

To Whom It May Concern,

This is to certify that Mr./Ms. , employed at , has undergone a medical evaluation.

Based on the assessment conducted on , the above-named individual is hereby declared:

- ☐ Fit to resume work
- ☐ Unfit to resume work (please specify reason):

Remarks:

Certified by:

Name:

Position:

License Number:

Signature: