

HEALTH CLEARANCE WAIVER CERTIFICATE

Full Name:

Date of Birth:

ID/Passport No.:

Contact Number:

I hereby declare that I am in good health and, to the best of my knowledge, free from any contagious or communicable diseases. I understand that this health clearance waiver is required as part of the documentation for entry, participation, or employment as applicable.

Date of Issue:

Signature of Applicant

Authorized Personnel