**MEDICAL CERTIFICATE OF VISA APPLICANT**

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| **PLEASE TYPE OR PRINT ANSWERS LEGIBLY IN THE SPACES PROVIDED (IF NOT APPLICABLE WRITE (N/A)** | | | | |
| PLACE | | DATE | | APPLICANT’S PHOTOGRAPH  2 in. x 2 in.   1. Picture taken within the past 6 months 2. Front View 3. Without eyeglasses 4. Write name at front bottom of photograph   Staple or past photo here |
| CITY | | COUNTRY | |
| **I CERTIFY THAT ON THE ABOVE DATE I EXAMINED** | | | |
| NAME | | | |
| AGE | SEX c MALE c FEMALE | | CITIZENSHIP |
| **And that under Philippine Immigration Regulations the applicant should be classified as follows:**  **(check the appropriate class** | | | | |
|  | | | | |
| **c CLASS A** | | **DANGEROUS AND/OR CONTAGIOUS DISEASE**  Chancroid, Gonorrhea, Grenolome Inguinale, Leprosy (Infectious), Lymphogranuloms Venerum, Syphilis (infectious stage), Tuberculosis (active) and AIDS | | |
| **SERIOUS MENTAL DISORDER**  Mental retardation (mental deficiency), insanity, previous occurrence of one or more attacks of insanity, antisocial personality, mental defects, Epilepsy, sexual deviation, narcotic drug addiction and chronic alcoholism | | |
| **c CLASS B** | | Persons having diseases or defects that will impair their ability to earn a living as to make them likely to be a public charge. | | |
| **c CLASS C** | | Persons having diseases or defects that do not come under Class A or B. | | |
| **c CLASS D** | | No physical or mental defects/disability. | | |
| **MEDICAL CONDITIONS**   1. **Pertinent medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 2. **Significant physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 3. **Chest X-ray report: (For ages 11 years and above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **Present X-ray film (14x17 inches) or CD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   1. **Laboratory Examination: (Attach laboratory reports):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 2. **Blood serology: (Ages 15 years and above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 3. **Urine: (Ages 1 year and above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 4. **Stool: (Ages 1 year and above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 5. **Other examination(s) if necessary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 6. **Not physically nor mentally defective or diseased:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| Examining Physician (Print Full Name):  Address and Telephone Number/s:  Signature of Examining Physician | | | | |