

+

**THE MATHIOYA TVC**

**P.O. BOX 363-10204, TEL: 0791 334 282**

**KIRIAI-INI**

**CERTIFICATE OF MEDICAL EXAMINATION**

1. Name of Candidate .....

Date of Birth .....ADM NO .....

2. Area to be examined medically

- (i) Vision
- (ii) Hearing
- (iii) Speech
- (iv) Posture
- (v) Physical defects/deformities, if any
- (vi) Symptoms of any infectious disease.
- (vii) Women student

Is the candidate pregnant?

**IMPORTANT NOTE:**

Expectant/married trainees are legible for admission

3. **CERTIFICATE**

I, Doctor .....has this date .....examined

.....and found her/him, fit/not fit for training in the course as  
admitted in.

Signature.....

Designation .....

Address .....

.....

Date .....

(OFFICIAL STAMP OF M.O.H.)