CERTIFICATE

MEDICAL CERTIFICATE OF HBS AG/MMR/ COVID- 19 / CHICKENPOX VACCINATION

I, Dr. .....Registration No.....
certify that I have on ..... day of ..... month of ..... year administered the HBS AG/MMR/ CHICKENPOX/ COVID-19 Vaccine to the candidate whose particulars given below:

1. Name of the Candidate :
2. Father's Name :
3. Gender :
4. Age :
5. Identification marks :
6. Dose : I / II / III
7. COVID-19 Vaccination : I / II / III

SIGNATURE OF THE APPLICANT

SIGNATURE OF MEDICAL OFFICER

NAME AND DESIGNATION

Place:

Date:

Office Seal