

**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 .....
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.)