OFFICIAL COVID-19 MEDICAL CLEARANCE CERTIFICATE

This document officially certifies that the patient named below has been clinically evaluated, has completed the mandatory isolation period and/or has tested negative for SARS-CoV-2, and is declared recovered and fit for travel, work, or public integration.

Patient Information

Full Name (As shown in Passport/ID): First and Last Name

Date of Birth (DD/MM/YYYY): 01/01/1990

Passport / National Identification Number: Document Number

Nationality: Country

Medical Assessment Details

Date of First Positive COVID-19 Test: DD/MM/YYYY

Date of Negative Confirmation Test (if applicable): DD/MM/YYYY

Type of Diagnostic Test Administered: RT-PCR / Rapid Antigen

Date of Clinical Recovery and Clearance: DD/MM/YYYY

Medical Status Confirmation: Asymptomatic / Fit to Tra

Authorized Medical Issuer

I hereby certify that the individual named above has undergone clinical evaluation and meets all government and public health recovery criteria to be cleared of COVID-19.

Name of Attending Physician / Medical Officer: Dr. Firstname Lastname

Medical Practitioner Registration/License Number: License Number

Medical Facility / Health Center Name: Hospital or Clinic Name

Facility Address & Contact Information: City, Country

Date of Certificate Issue: DD/MM/YYYY

Official Signature / Medical Stamp Field: Signee Name / Authority