



COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2019

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PART A: (TO BE FILLED BY APPLICANT)

1. Name _____ S/o;D/o; W/o _____

Address _____

2. Date of Birth _____ Identification mark: _____ Blood group: _____

3. DECLARATION: Have you suffered from or have history of any of the following:

- | | | | |
|------------------------------|---|------------------------------------|--|
| a) Breathlessness | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | b) Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Respiratory/ lung ailment | <input type="checkbox"/> Yes <input type="checkbox"/> No | d) High Blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) Blood disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | f) Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g) Bleeding tendencies | <input type="checkbox"/> Yes <input type="checkbox"/> No | h) Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i) Heart ailment | <input type="checkbox"/> Yes <input type="checkbox"/> No | j) Nervous breakdown | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k) Joint Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | l) High altitude/mountain sickness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m) Discharge from ear | <input type="checkbox"/> Yes <input type="checkbox"/> No | n) History of stroke/ paralysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| o) Are you a smoker | <input type="checkbox"/> Yes <input type="checkbox"/> No | p) Are you pregnant: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

(applicable to female Yatris)

q) History of Heart Attack; if yes, please specify _____

r) History of sudden death in family members; if yes, please specify _____

s) Any major injury in the past; if yes, please specify _____

t) Any other ailment; if yes, please specify _____

u) History of surgery; if yes, please specify _____

v) Are you under any medication; if yes, please specify _____

w) Are you allergic to drugs, foods and chemicals; if yes, please specify _____

4. I hereby declare that the particulars given above are true to the best of my knowledge and belief, and nothing has been concealed.

Date _____

Signature/ thumb impression of the Applicant)

PART B: (TO BE FILLED BY AUTHORISED MEDICAL AUTHORITY)

On the basis of information furnished by the applicant, detailed examination and the necessary investigations, it is certified that Mr/Ms/Mrs _____ is fit to undertake the journey to the Shri Amarnathji Holy Cave Shrine.

Details of any specific test conducted before issuing the certificate: _____

Name of the Doctor _____

Designation: _____

Date of issue: _____

Signature and seal of Authorized Medical Authority
MCI/ State Medical Council Registration No: _____