

Annexure-I

COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2017

Affix cross-signed (by Yatri) recent photograph

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 [] Yes [] No b) Diabetes [] Yes [] No
c) Respiratory/ lung ailment [] Yes [] No d) High Blood pressure [] Yes [] No
e) Blood disorder [] Yes [] No f) Asthma [] Yes [] No
g) Bleeding tendencies [] Yes [] No h) Epilepsy [] Yes [] No
i) Heart ailment [] Yes [] No j) Nervous breakdown [] Yes [] No
k) Joint Pains [] Yes [] No l) High altitude/mountain sickness [] Yes [] No
m) Discharge from ear [] Yes [] No n) History of stroke/ paralysis [] Yes [] No
o) Are you a smoker [] Yes [] No p) Are you pregnant: [] Yes [] 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 undergoing 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: _____

