TARLAC STATE UNIVERSITY
MEDICAL SERVICES OFFICE

MEDICAL CERTIFICATE

NAME: _____

AGE: _____ SEX _____ CIVIL STATUS: _____

ADDRESS: _____

IMPRESSION:

☐ FIT

☐ WITH MEDICAL CONDITION/S (SPECIFY): _____

_____

_____

COVID19 VACCINATION

		VACCINE NAME		VACCINE DATE
☐ FIRST DOSE	-	_____	-	_____
☐ SECOND DOSE	-	_____	-	_____
☐ BOOSTER DOSE	-	_____	-	_____
☐ BOOSTER DOSE	-	_____	-	_____

_____

PHYSICIAN (signature over printed name)

PRC LIC. NUMBER: _____