



# COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2018

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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 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: \_\_\_\_\_