

COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2015

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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 | ☐ 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: _____