COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2023

Paste recent passport size photograph here

PART A: (TO BE FILLED BY APPLICANT)

1. Name: _____ S/O, D/O, W/O: _____
2. Address: _____
3. Date of Birth: _____/_____/_____ Aadhaar No.: _____/_____/_____ Blood Group: _____
4. Identification Mark: _____

Age limit:
a) For Yatri: Should not be less than 13 Years or more that 70 Years old.
b) No lady with more than 6 weeks pregnancy will be registered for the Yatra 2023

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

S. No	Condition	Yes	No	S. No	Condition	Yes	No
A)	Breathlessness			**B)**	Diabetes		
C)	Respiratory/Lung ailment			**D)**	High Blood Pressure		
E)	Blood disorder			**F)**	Asthma		
G)	Bleeding tendencies			**H)**	Epilepsy		
I)	Heart ailment			**J)**	Nervous breakdown		
K)	Joint Pains			**L)**	High altitude/mountain Sickness		
M)	Discharge from ear			**N)**	History of stroke/ paralysis		
O)	Are you a smoker			**P)**	Are you pregnant **(Applicable to female Yatris)**		

- History of Heart Attack, if yes please specify_____
- History of sudden death in family member, if yes please specify_____
- Any major injury in the past, if yes please specify_____
- Any other ailment, if yes please specify_____
- History of surgery, if yes please specify_____
- Are you under any medication, if yes please specify_____
- Are you allergic to drugs, foods and chemicals, if yes please specify_____

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 Yatri)**

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: …….