Annexure II

COMPULSORY HEALTH CERTIFICATE FOR KUMBH MELA HARIDWAR - 2021

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) History of stroke/ paralysis	☐ Yes ☐ No
m) Are you a smoker	☐ Yes ☐ No	n) Are you pregnant: (*applicable to female Yatris*)	☐ Yes ☐ No

o) History of COVID-19 Infection ☐ Yes ☐ No, if Yes date of COVID-19 Positive Report_____

p) History of Heart Attack;if yes, please specify_____

q) History of sudden death in family members; if yes, please specify_____

r) Any major injury in the past; if yes, please specify_____

s) Any other ailment; if yes, please specify_____

t) History of surgery; if yes, please specify_____

u) Are you undergoing under any medication; if yes, please specify_____

v) Are you allergic to drugs, foods and chemicals; if yes, please specify_____

w) Date of Latest COVID-19 Testing result. Date_____ Positive☐ Negative☐

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 KUMBH MELA HARIDWAR 2021.

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:_____