# Medical Fitness Certification

Date: [Insert Date]

To Whom It May Concern,

This is to certify that:

**Name:** [Patient's Full Name]

**Date of Birth:** [Patient's Date of Birth]

**Address:** [Patient's Address]

Has been examined by me on [Examination Date] and found to be in good physical and mental health. This individual is fit for the purpose of participating in [specific activities or events, e.g., physical activities, travel, etc.].

The individual does not have any medical conditions that would contraindicate participation in the aforementioned activities.

This certification is issued upon the request of the patient for the purpose of insurance claims.

If you have any questions or require further information, please do not hesitate to contact my office at [Doctor's Phone Number] or [Doctor's Email Address].

Sincerely,

[Doctor's Name]

[Doctor's Qualifications]

[Medical Practice Name]

[Address]

[Phone Number]

[Email Address]