**MEDICAL STATEMENT** (*Statement of Good Health*)

Students/Patient

Name :

Nationality :

Date and place of birth :

Address :

I have examined the individual named above and to the best of my knowledge, she/he is in good physical and mental health, free of any communicable diseases and is able to participate in his/her upcoming semester abroad at IDB Bali.

By signing below I certify that the above information is true.

Doctor’s name :

Office Phone Number :

Date of Examination :

Office Address: Signature & Office Stamp (If any) Available)

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