



**REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HOME AFFAIRS
MEDICAL CERTIFICATE**

CONDITIONS OF A RECURRENT NATURE

Although the person(s) may be generally in a good state of health at the time of the examination, it would be appreciated if the medical officer/practitioner could furnish details of any disease, condition or defect the person(s) has/have suffered and which might recur.

I hereby certify that I have examined the following person(s):

1 5
2 6
3 7
4 8

and find him/her/them:-

- (a) not mentally disordered or physically defective in any way;
- (b) not suffering from leprosy, venereal disease, trachoma, tuberculosis or other infectious or contagious condition;
- (c) generally in a good state of health;

except for the following defects observed:

Name of person(s) **(Please type or print)**
Details regarding the disorder, disease or disability, the seriousness thereof and the treatment, if any, prescribed/recommended

1.....
2.....
3.....
4.....

Official stamp and address of medical
officer/practitioner/hospital

.....
Signature of Medical officer/practitioner

Date

Int. Code	"Mentally disordered" includes the following
290-299	All psychoses.
300	Neuroses.
301	Personality disorders.
303-304	Addictions.
308	Behaviour disturbances of childhood.
310-315	All forms of mental retardation.
320-349	Epilepsy and all other forms of degeneration of the central nervous system.



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RADIOLOGICAL REPORT**

Note:

- (1) A radiological report of the chest is required in respect of every prospective immigrant 12 years of age and over.
- (2) The radiologist must insert the names of the prospective immigrants examined by him in the space provided for that purpose on the form. Unused spaces must be crossed out.
- (3) A separate report is required in respect of every applicant suffering or suspected to be suffering from tuberculosis.

I hereby certify that I have radiologically examined the chest(s) of the following person(s) and that I could find no sign of active pulmonary tuberculosis.

Name:

- (1)
- (2)
- (3)
- (4)
- (5)

Official stamp and address of Radiologist/hospital:

..... Radiologist Date
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