



# COMPULSORY HEALTH CERTIFICATE FOR SHRI AMARNATHJI YATRA 2024

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## 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 2024

## 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 ( <b>Applicable to female Yatris</b> )		

- 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: .....