

MEDICAL ASSESSMENT
GIẤY CHỨNG NHẬN SỨC KHỎE

Date :.....

TO WHOM IT MAY CONCERN :

RE : _____

D.O.B. _____

SS # _____

This is to certify that :.....

Has been treated at my office for the following conditions :

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PHYSICIAN'S OPINION :

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Physician's name : _____

Address : _____

Telephone : () _____

Physician's Signature : _____

Note : This form is for membership application purpose only.
QUỖ TƯƠNG TẾ VIỆT NAM – 1115 E. Santa Clara St. Suite #1, San Jose, CA. 95116
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