Food Handlers Medical Certificate

THE REPUBLIC OF TRINIDAD AND TOBAGO
FOOD HANDLER'S MEDICAL EXAMINATION CERTIFICATE

PLACE PHOTO HERE

Name: …….

Sex: Male ( ) Female ( ) **Date of Birth: ……**

ID NUMBER /DP/PP …… **Phone Contact: ……**

Home Address:
……

……

Personal History: tick where appropriate:

(1) Typhoid	**Yes ( )**	**No ( )**
(2) Tuberculosis:	**Yes ( )**	**No ( )**
(3) Jaundice	**Yes ( )**	**No ( )**
(4) Chronic Cough	**Yes ( )**	**No ( )**
(5) Leptospirosis	**Yes ( )**	**No ( )**

(6) Have you suffered from diarrhoea and/or vomiting in the last seven (7) days? Yes ( ) No ( )

(7) Other ……

(8) Hospitalization – Yes () No ( ). If yes, state reasons

……

(9) Travel History

State Country visited within the last six weeks ……

(10) Examination (Circle appropriate letter – S- Satisfactory; - U – Unsatisfactory)

Hair – S / U	**Eyes – S/U**	**Mouth – S / U**	**Throat S / U**	**Skin – S / U**
Hands - S / U	**Nails – S / U**	**Feet S / U**	**General Appearance – S / U**	

Referral: ……

Having examined this person, I certify that he/she is free from any signs or symptoms of communicable/infectious diseases or from any sore, eruption, or other affliction of the body and is fit to handle food.

Date Examined: …….

…… **……**
Official Stamp **Medical Officer**

……
Telephone No.

LHA/PTRC