To INSTITUT LYFE ID
1A chemin de Calabert
69130 Écully
ECULLY FRANCE

MEDICAL FITNESS CERTIFICATE

(Professional Culinary Training Program)

I, Dr. _____ _____
licensed medical practitioner, hereby certify that:
Mr./Ms _____ _____
Date of Birth: ___ / ____ / _____.
has undergone a medical examination on ___ / ____ / _____.
Based on this examination and on the medical information available to me, I confirm that he/she:

- Is in good general physical and mental health.
- Is fit to participate in practical culinary training activities.
- Is medically fit to work in a professional kitchen environment, including food preparation and food handling areas.
- Does not present any communicable disease or medical condition that would pose a risk in a food production or collective catering environment, in accordance with current hygiene and food safety standards.

This certificate is issued for enrollment and participation in a hospitality/culinary training program.
Issued at the request of the above-named individual for academic purposes.

Name of Physician: _____

Medical License Number: _____

Contact Details: _____

Signature of Physician **Stamp**

Date: