|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CONTROL OF PLANTS ACT (CHAPTER 57A)  CONTROL OF PLANTS (CULTIVATION OF PLANTS)  **(LICENSING AND CERTIFICATION) RULES** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| CERTIFICATE OF FITNESS | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Name of Person examined: | | | | | | |  | | | | | |
| Identification Number: | | | | | | |  | | | Gender: | Male  Female | |
| Date of Birth: | | | | | | |  | | | Race: |  | |
| Name and Address of Employer / Farm: | | | | | | |  | | | | | |
| Examination/Tests done and results of: \* | | | | | | | | | | | | |
| I, | |  | | | hereby certify that I have examined the above above-named | | | | | | | |
|  | | (Name of Doctor) | | |  | | | | | | | |
| person on | | |  | | and that he/she is fit/ not fit for work in horticultural farms | | | | | | | |
|  | | | (Date) | |  | | | | | | | |
| which may expose him/her to pesticide poisoning. | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Remarks (if any): | | | | | | | | | | | | |
|  |  | | |  | |  | |  |  | | |  |
|  | Signature | | |  | | Date | |  | Name and Address of Practice | | |  |
|  | | | | | | | | | | | | |
| *Footnote:*  *\* Fill and/or attach results of the tests done, in particular:*   1. *a general medical examination to certify that he/she is fit for farm work* 2. *a clinical examination for signs and symptoms of organophosphate poisoning* 3. *a red blood cell acetyl cholinesterase estimation (lab test)* | | | | | | | | | | | | |