



FIREARMS HEALTH CERTIFICATION FORM

I, [Doctor's Full Name] _____, [Doctor's Medical License Number] _____, a licensed and practicing physician, hereby certify that after conducting a medical evaluation of [Full Name of Applicant] _____, [Identification Card / Passport Number] _____, and also having reviewed their medical history, **I find no current medical or psychological conditions that would impede their physical or mental fitness to keep and/or use a firearm.**

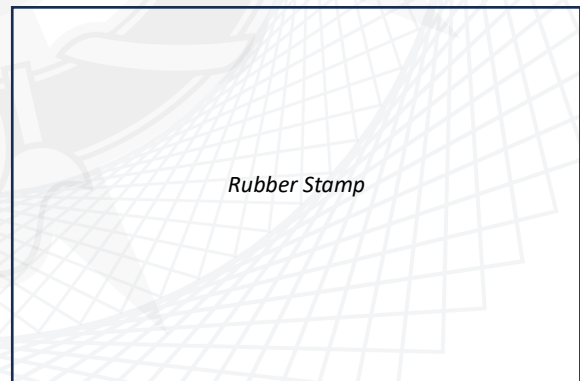
This certification is based on my professional judgment and expertise as a qualified medical practitioner. I affirm the accuracy and truthfulness of the information contained herein to the best of my knowledge and belief.

I also acknowledge that this certification will be used by the Malta Police Force as part of their assessment process for [Full Name of Applicant] _____ firearm license eligibility.

Signature: _____

Date: _____

This certification reflects the applicant's health status at the time of examination.



DOCTOR'S FULL NAME, TITLE, AND CONTACT INFORMATION

[Name of Medical Practice, Clinic, or Hospital] _____

[Email Address] _____