

CERTIFICATE OF MEDICAL FITNESS

To be obtained any Govt./Registered Medical practitioner Having MBBS Degree.

Please note that this is the preferred form of certificate to be accepted.

NAME.....
AGE.....MALE/FEMALE.....D.O.B.....
ADDRESS.....
MOB. NO.
FOR JOB TYPE FIELD

HISTORY/CASE

- 1) Known Case of Thyroid...../ Diabetes...../ B.P...../ Sugar..... |
 - 2) Use of Spectacles Yes...../ No..... |
 - 3) Any Addictions Alcohol.....Cigarette.....Others..... |
 - 4) Any Specific Disease.....
 - 5) Any Hereditary Disease.....
 - 6) Any Gynecological Complaint.....
 - 7) Any Vision L R
 - 8) Color Vision.....
 - 9) Hearing.....
 - 10) Hernia/Hydrocele/Piles.....
 - 11) Heart & Lungs.....
 - 12) Operation/Disability/AnyOther.....
 - 13) Any Mental Complaints.....
 - 14) Any Medical Treatment from other Doctors.....
-

PHYSICAL CHECK UP

- | | | | |
|------------------------|-------------|----------------------------|------------|
| 1) Height..... | Weight..... | Abdomen..... | Chest..... |
| 2) B.P. | | 6) CORONA History | |
| 3) Blood Glucose | | 7) Vaccination Dates | |
| 4) Temperature | | 8) Respiratory Rate | |
| 5) Pulse | | 9) ANY OTHER | |

REMARK & SUGGESTION

I here that I have carefully examined

*Mr. / Ms.Son/Daughter of
Shriwho has signed in my
presence. He / She has no mental and physical disease and is FIT.*

Date: _____

Place: _____

Candidate Signature

Signature & Stamp of Govt./Registered Practitioner
Having Degree with legible

