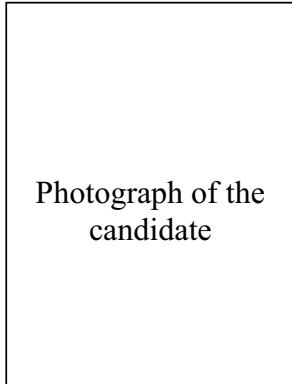


**MEDICAL CERTIFICATE (ENTRY - 2015)**  
**[TO BE SUBMITTED BY THE SELECTED CANDIDATES ONLY ]**

No. \_\_\_\_\_ Date: \_\_\_\_\_

Place of Issue \_\_\_\_\_



Application No. : \_\_\_\_\_

Name of Applicant : \_\_\_\_\_

Father's Name: \_\_\_\_\_

**Gender:** \_\_\_\_\_

**Age:** (on 1<sup>st</sup> Oct . 2015): Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Identification Mark: \_\_\_\_\_

**Medical Examination**

<i>Type of Medical Examination</i>		<i>Results</i>	
Eye	Vision	R. Eye	
		L. Eye	
	Color Vision		
Ear	R. Ear		
	L. Ear		
Chest X – Ray			
Systematic Examination	B. P.		
	Heart		
	Lungs		
	Abdomen		
Others	Hernia		
	Extremities		
	Varicose Veins		
	Skin		
Venereal Diseases:		Clinical:	
Neurological / Psychiatric evaluation			

**Laboratory Investigation**

<i>Type of Medical Examination</i>		<i>Results</i>	
Urine	Sugar		
	Albumin		
Stool Routine Examination			
C/P Blood with ESR			
HIV / HBV / HCV			

**History of Past Illness**

Any history of admission in hospital more than ten days	Yes / No	Syncope	Yes / No
Epilepsy	Yes / No	Asthma	Yes / No
D. M.	Yes / No	Tuberculosis	Yes / No
PU	Yes / No	Hydrocoele	Yes / No
IHD	Yes / No	Hernia	Yes / No
Stroke	Yes / No	Vericocele	Yes / No
Operation	Yes / No	Foreign Visit	Yes / No
Blood Transfusion	Yes / No	Vaccinated	Yes / No

Remarks:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FIT / UNFIT**

Signature & Office Seal: \_\_\_\_\_