FORM (F-V)

MEDICAL CERTIFICATE (ENTRY - 2015)

[TO BE SUBMITTED BY THE SELECTED CANDIDATES ONLY]

No. _____ Date: _____

Place of Issue _____

Photograph of the candidate

Application No. : _____

Name of Applicant : _____

Father's Name: _____

Gender: _____

Age: (on 1st Oct . 2015): Years _____ Months _____ Days _____

Identification Mark: _____

Medical Examination

Type of Medical Examination			***Results***
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

Type of Medical Examination		***Results***
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: _____