MEDICAL FITNESS CERTIFICATE

Medical Fitness Certificate to be issued by Registered Medical Practitioner

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Name: _____; **Gender:** _____

Date of Birth: _____ **Name of the Course :** _____

Indicate your response by ticking (√) the appropriate one

1. Do you have any minor or major complaint? Yes / No

   If Yes, describe_____

2. Are you allergic to any medicine or any others? Yes / No

   If Yes, describe _____

3. Have you ever had any operation or been advised any operation? Yes / No

   If Yes, describe _____

4. Are you Physically Challenged? Yes / No

   If Yes, Indicate: Visual / Hearing / Orthopedic

I declare that the above information is true to the best of my knowledge.

Signature of the Candidate

I.	General Information	: Height: _____cms; Weight: _____kgs
II.		Insp: _____cms; Exp: _____cms; Resp.Rate: _____/min
		B.P: _____mm HgPulse: _____/min.
III.	Blood Group & Rh type	: _____
IV.		
V.	Personal marks of Identification	: 1 _____
VI.		2 _____
VII.	C.V.S.	:
VIII.	Respiratory System	:
IX.	G.I.System	:
X.	C.N.S	:
XI.	Musculoskeletal System	:
XII.	Examination of Eyes	:
XIII.	E.N.T	:
XIV.	Urinary System	:
XV.	Remarks	:

I do hereby certify that I have examined the above candidate. He / She is fit to join the above mentioned course.

Date:
Place:

REGISTERED MEDICAL OFFICER
(Seal with Reg.No.)