PHYSICAL EXAMINATION FOR MEDICAL FITNESS CERTIFICATE

No ____/__________/ Dated.______________

Mr./Ms./Mrs.____

S/O, D/O, /W/O.____

Age. _______Sex. _____________Designation.____

Place of Birth. _________________________ Passport # _________________________________

Country applied for.____

General Examination:

Height_______ Weight ________ Physical Deformity (if any) ____________________________

B.P._____________ mmHg, ______min, Pallor______________ Clubbing__________________

Lymph node___________ Thyroid ___________ Skin__________________________________

Eye Sight:

Right Eye _______________

Left Eye_________________

Hearing:

Right Ear__________________

Right Ear__________________

Heart __________________

Chest______________________

Abdomen_______________

C.N.S____________________

Investigations:

X-Ray Chest ____________________

Blood Group_______________

Blood CP&ESR_________________

VDRL Syphilis_____________

Urine R/E ______________________

HIV_______________________

Anti HCV/HB AG's ______________

Any other_________________

Remarks: FIT / UNFIT / DEFERRED

(To be signed and stamped by authorized Medical Officer of Government Hospital)