

MEDICAL CERTIFICATE (ENTRY 2020)

[TO BE SUBMITTED BY THE SELECTED CANDIDATES ONLY]

Photograph of the candidate	No. _____ Date: _____
	Place of Issue _____
	Application No. : _____
	Name of Applicant: _____
	Father's Name: _____
	Gender: _____
Age: Years _____ Months _____ Days _____	

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		

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

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: _____