MEDICAL CERTIFICATE

[to be submitted by the selected candidate only]

Photograph of the candidate

No. : _____ **Dated:** _____

Place of Issue: _____

Application No. : _____

Name of Candidate : _____

Father's Name : _____

Sex : _____ Date of Birth: _____

Identification Marks : _____

Medical Examination

Type of 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		
Veneral Diseases:		Clinical:	
Neurological / Psychiatric evaluation			

Laboratory Investigation

Type of 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	Hydrocele	Yes / No
IHD	Yes / No	Hernia	Yes / No
Stroke	Yes / No	Vericocele	Yes / No
Operation	Yes / No	Foreign Visit	Yes / No
Blood Transformation	Yes / No	Vaccinated	Yes / No

Remarks _____

Counter Signed by: _____
Medical Superintendent, DHQ

Signature & Official Seal: _____
Civil Medical Officer