MEDICAL FITNESS CERTIFICATE

Name of Candidate (Block Letters)						Photo of Candidate duly attested by
Father's Name						undersigned Doctor
Age (in Yrs)			Sex	Male/ Female		
Height (in cm) Blood Group			Weight (Kg)			
Vision Colour vision			0			
Hearing	Left		Right			
Vaccination status	Hepatitis B		//	(Final dose date)		
	Tetatnus		//	(Last dose date)		
	Covid 19		/	(Final dose date)		
Past History (Tick the relevant)	Diabetes / Hypertension / B. Asthma / epilepsy / Hypothyroidism / Tuberculosis / Depression/ any other					
Treatment/ medication History (if any)						
Family History						
Personal History	Addiction to	Tobacco/ c	igarette/ Alcol	nol/ any other		
Allergies	Drug ()/	Food/any oth	er		
I, Dr			•			•
certify that Mr						
found to be clinicaly fro			•	/ fit to undergo pro	fessional edu	cation. He/ she has
Todila to be emileary in	ce mom any c	om ome dise	usc			
Identification Marks		1				
		2				
His/ her signature is a	ttested belov	v.				
Signature of Candidate	e				_	e of Doctor Designation
Date:					Regn. N	o .
Place:					Stamp/S	Seal