



Declaration Form

Details Filled by the Candidate

Name	:	
Date of Birth	:	
Male / Female	:	
a. Any family history of Blood Pressure/ Diabetes		
b. Any Deformity/Amputation?		
c. Any history of epileptic seizure/ Vertigo? If yes then the date of last seizure		
d. Do you have any allergies or reactions to drugs?		
e. Have you had any anxiety disorder or suffered from depression?		
f. Are you currently taking any medication? If yes, please list down the illness and name of medicines.		
g. Have you had any major illness/ surgery/ transplant/ accident/ hospitalisation?		

Declaration : I the undersigned accept that all the information provided by me is true and the medical center or the company is not liable medicolegally for the same.

Signature of Candidate					
Details Filled by Centre					
1. Height	2.. Weight	3.Build		4. Pulse	5. Blood Pressure
Cms	Kg	Normal			
		Under weight			
		Over weight			

6. Visual Acuity Whether he/she falls in the category of visually impaired				
Eye	Near Vision	Far Vision	Color Vision	
Right				
Left				
7. General examination findings:				
8. Complete Blood Picture:				
9. Urine Examination:				
10. Diabetes Profile (if in Package):				
11. Lipid / Kidney / Liver Profile (if in Package):				
12. Respiratory Tract (Chest X Ray/PFT):				
13. Cardiac Risk Profile(ECG/TMT/2D ECHO):				

FITNESS			
Fit			
Recommendations (If Any)	Test		
	When to DO		
	Reason		
	Advice / Medicine		
Unfit with recommendation	Test		
	When to DO		
	Reasons		
	Advice / Medicine		
Place		Physician's Name,Qualification & Signature (With Stamp)	
Date			