PHYSICAL EXAMINATION FOR MEDICAL FITNESS CERTIFICATE

No ____/_____/ Dated._____

Mr./Ms./Mrs._____

S/O, D/O, /W/O._____

Age. _____Sex. _____Designation._____

Place of Birth. _____ CNIC # _____

Job applied for._____

General Examination:

Height_____ Weight _____ Physical Deformity (if any) _____

B.P._____ mmHg, _____min, Pallor_____ Clubbing_____

Lymph node_____ Thyroid _____ Skin_____

Eye Sight: **Hearing:**

Right Eye _____ Right Ear_____

Left Eye_____ 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/Private Hospital)