

Medical Certificate of Fitness

Please fill in the complete form, sign it and hand over to your Induction Coordinator

To be filled by Candidate

Candidate's Personal Details:

Mr./Mrs./Ms./Miss/Dr. First Name: Sonal Last Name: YadavGender: ☒ Male ☐ FemaleDate of birth (DD/MM/YY) 20/08/2001Contact No: (M) 8959177006 (R) _____Blood Group: A+

Candidate's Medical History:

DR. HIRDESH TRIVED

MEDICAL OFFICER

Candidate's Medical Details	Yes	No	Please provide the details
Do you suffer from any defect of vision? If Yes, has it been corrected by suitable spectacles?		<input checked="" type="checkbox"/>	
Can you readily distinguish between the pigmentary colors, Red and Green?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you suffer from a degree of deafness which would prevent your hearing of normal conversation and ordinary sound signals?		<input checked="" type="checkbox"/>	
Do you have any physical deformity / handicap or use any mechanical / physical assistance for mobility?		<input checked="" type="checkbox"/>	
Do you have any congenital disorder / abnormality?		<input checked="" type="checkbox"/>	
Have you ever been diagnosed to have any Psychiatric ailment including Depression, Anxiety Neurosis, Phobic Disorders, Schizophrenia, Manic Depressive Psychosis or any other Psychiatric illness?		<input checked="" type="checkbox"/>	
Have you had any form of critical illness or operation in the last two years?		<input checked="" type="checkbox"/>	
Have you ever been disqualified on medical grounds from any previous employment opportunity?		<input checked="" type="checkbox"/>	
Have you ever been diagnosed with or do you suffer from any other Medical condition that may require you to take Medical Leave over the next 12 months?		<input checked="" type="checkbox"/>	
Have you ever been diagnosed to have Cancer, Tumor, Cyst or any similar type of growth?		<input checked="" type="checkbox"/>	
Have you ever been diagnosed with an alcohol or drug abuse problem? If yes, are you on treatment for the same?		<input checked="" type="checkbox"/>	

Have you ever suffered or suffering from any of the following? (Please (✓) tick wherever applicable and provide necessary details.)

Valve Disorders	High Blood Pressure	Stroke
Heart Attack	Diabetes	Tuberculosis
Angina Pectoris	Asthma	Slipped disc
Arthritis	Obesity	Epilepsy
Night Blindness	Hepatitis B	Hepatitis C