



Hospital Indian Institute of Technology Delhi

Medical Examination

Form v. 0.2(July 2014)

Purpose of this form: To record your demographic details briefly, personal medical history in detail, and the medical opinion of the examining physicians on your fitness to serve as an employee of Indian Institute of Technology Delhi.

Typical use of this form: Used during the joining process.

Please give us some feedback when you are done:

- Time taken to complete this form (minutes):
- Was this form repetitive? If so, which parts of this form could be removed to reduce paperwork?
- Was this form redundant? If so, which other form could replace or subsume this?
- Are all levels of approval specified actually needed for its processing? If not, which ones could be dispensed with?

For optimal results, please use Adobe Acrobat® Reader® when filling up this form online. Any fields that are not relevant to your situation should include "N/A" (not applicable) as your response. Designation refers to the position you were offered.

Form Submission Chain: You→Hospital, You→Your HOD/HOC, You→Establishment-I

Basic Demographic Information

The signatures by the Head of your Department / Center and Establishment-I need only be obtained after your medical examination is complete. Please provide fingerprints of your right hand, and accede to any other reasonable requests from the medical staff when asked. We apologize for any inconvenience.

Full Name

Date of birth

Place of birth

Present address

Parents' Full Names

Parents' Address(es)

Precise height in cm

Identifying marks (if any)

Designation

YOUR SIGNATURES

DATE:

HEAD OF DEPARTMENT / CENTER

SUPERINTENDANT, ESTABLISHMENT-I

Medical Background

Past illnesses

Have you ever presented any of the following conditions or symptoms?

Small-pox

Enlargement or suppuration of glands

Exsanguination or spitting of blood

Heart Disease

Respiratory illness

Fainting attacks

Rheumatism

Appendicitis

Anxiety (from overwork, etc.)

Any illness requiring bed rest and medical/surgical treatment

If you answered yes to any of the above, please provide details.

Details

Have you or your near relatives ever been diagnosed with the following conditions?

Tuberculosis

Scrofula / Lymphadenitis

Gout

Asthma

Seizures

Epilepsy

Severe mental dysfunction

If you answered yes to any of the above, please provide details.

Details

Prior determinations

Have you been examined and declared unfit for Government of India service or employment in an autonomous organization by Medical Officer/Board, in the last 3 years?

.....

If you answered yes to the above question, please provide details.

Details

Vaccination/Inoculation Record

For each vaccine you have received, enter date in which you received it (or completed the course). For others, enter "N/A".

Vaccine	Date of Vaccination
Hepatitis A	
Hepatitis B	
Rabies	
Yellow Fever	

Diphtheria-Tetanus-Pertussis
(DPT)

Measles-Mumps-Rubella
(MMR)

Varicella (Chicken Pox)

Polio

Typhoid

Japanese Encephalitis

Small Pox

Influenza

Pneumonia

Others (name(s) and date(s))?

Family medical background

Is your father living at this time?

If living, enter current age,
else enter age at time of
death

If living, enter current
state of health, else cause
of death

Is your mother living at
this time?

If living, enter current age,
else enter age at time of
death

If living, enter current
state of health, else cause
of death

Number of brothers alive
at this time, their age(s)
and state of health?

Number of brothers dead
at this time, their age(s)
at their time of death, and
cause(s) of death?

Number of sisters alive at
this time, their age(s) and
state of health?

Number of sisters dead at
this time, their age(s) at
their time of death, and
cause(s) of death?

Biometrics

Fingerprints for identification purposes

Thumb	First Finger	Second Finger	Third Finger	Fourth Finger

Mandatory statement by prospective employee

If applicable, I solemnly affirm that I have not received a disability certificate pension on account of any disease or other condition.

Additionally, I understand that in case I perjure myself with respect to any information provided in this form, I incur the risk of losing this position, and the attendant risk of forfeiture to all claims to superannuation allowances and gratuity, regardless of how long I held this position, prior to discovery of any perjury.

I declare that my statements above are true to the best of my knowledge, and belief, and are made without any mental reservation, or purpose of evasion.

YOUR SIGNATURES

DATE

FOR OFFICE USE

Statement by Medical Officers

The Medical Board¹, constituted to medically examine prospective employees for their suitability for employment at Indian Institute of Technology Delhi, met on _____. We carried out the required laboratory tests and other medical examination of this prospective employee.

We hereby certify that we:

- have examined the aforementioned person, who is a prospective employee of Indian Institute of Technology Delhi, and
- judge this examinee's age to be _____ years, consistent with a self-declared age of (_____ years), and observe that:

no disease, chronic illness, or physical infirmity has been discovered

the undermentioned condition has been discovered, but we do not consider it to be a disqualification for employment at Indian Institute of Technology Delhi

¹In case of female examinees, at least one of the examining medical officers must also be female, by law.

the undermentioned condition has been discovered, and we consider it to be a disqualification for employment at Indian Institute of Technology Delhi

- this examinee has been found to suffer from _____.

MEDICAL OFFICER 1

DATE

MEDICAL OFFICER 2

DATE

CHIEF MEDICAL OFFICER

DATE

Medical