**Please hand over the completed form to your Induction Coordinator**

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| **Medical Certificate of Fitness** | |
| **Section 1: Candidate’s Personal Details** | |  | | --- | |  |   \_\_\_\_\_\_\_\_\_Savitha\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name:** S\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of birth (DD/MM/YY) \_01\_/02\_/2003\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Blood Group:** \_0+\_\_\_\_ |
| **Please fill in the complete from and sign it.**    **Mr./Mrs./Ms./Miss/Dr First Name:**  **Gender: Male**  **Female ✓**  **Contact No: (M)** 6363299397\_\_\_\_\_\_\_ **(R)** |



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| **Candidate Statement** | Yes No. If yes, please provide the details  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any physical deformity / handicap or use any mechanical / physical assistance for mobility? Yes No. If yes,  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No**.** Ifyes, please provide the date and  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No. If yes, please provide the  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  employment or you not performing a specific role in the past? Yes No. If yes,  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Bronchitis  Obesity  Diabetes  Arthritis  Drug abuse  Heart Disease  Skin Infection  Bowels  Epilepsy  Thyroid Ailment  Arthritis  Asthma  Liver disease    Have you ever suffered or suffering from any other illness or impairment not mentioned above? Yes No. If yes, please  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any congenital defect / abnormality?      please provide the details        Have you had any form of serious illness or operation in the last two years?    details of the surgery        Have you been treated or hospitalized for cancer, Tumor, Cyst or any other growth?  details      Has medical grounds been a reason for unplease provide the details        Have you every suffered or suffering from any of the following?  High Blood Pressure  Stroke  Blood Spitting  Peptic Ulcer    Heart Murmur  Tuberculosis  Heart attack  Slipped disc    provide the details |

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| **Declaration** | **that to the best of my knowledge, the answers to the questions in this form are correct and that I am not suffering**  **from any disease/illness, the presence of which I have not revealed. I fully understand that any misrepresentation of this lead to the termination of my offer/appointment. I have no objection to Tata Consultancy Services Pvt. Ltd.**  **seeking further information either directly from me or from my Consulting doctor or other appropriate doctor. In case of any t of my declaration, I will be undergoing the medical check-up by the Company’s suggested medical**  **clinic/doctor and their findings will be fully binding on me and any action thereon towards my employment will be accepted**  **Date: (DD/MM/YY) \_\_\_/11\_/22\_** |
| **I declare**    **declaration could**    **discrepancy arising ou**    **by me.**    **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Section 3 -** TheCandidate needs to ensure that a legally qualified and registered medical practitioner with minimum qualification as M.B.B.S. completes this form. Additional sheets may be attached if more space is required.

**Note: The candidate is responsible for any cost****s associated with the preparation of this report.**

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| **Section 3: Medical Practitioner’s details** | **) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Full name (as listed on applicable state registry****Registration ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Postal Address:**  **Contact No: (Day time) \_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Section 4: General Examination** | **BP: \_\_\_\_\_\_\_\_\_\_\_mm Hg;** | **Height: \_166\_ cms;** |
| **Body wt: \_58\_ kgs; Pulse: \_\_\_\_\_\_ /min;** |
| **Declaration** | Mr./Mrs./Ms./Miss/Dr \_Savitha S\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son/daughter of Mr.    Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date: (DD/MM/YY) \_\_\_/11\_/22\_** | |
| I, certify that I have carefully examined  \_Srinivas\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  He/she is medically fit/unfit for employment with TCS.        **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **& Sealed** |

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