

## LIST OF FORMS

List of Forms for pre-employment Medical Examination are:

Form 1 - Candidate's Statement and Declaration.

Form 2 - Examining Physician's Report.

Form 3 - Medical Certificate of Fitness for Employment.

## FORM - 1

### CANDIDATE'S STATEMENT AND DECLARATION

The candidate must make the required statement below prior to his medical examination and may sign the declaration appended thereto. His attention is specially directed to the warning contained in:

1. State your name in full (in block letters) : \_\_\_\_\_
2. State your age, date of birth and place : \_\_\_\_\_
3. (a) Have you ever had chickenpox, small Pox, intermittent or any other fever, glands, spitting of blood, asthma, attacks, rheumatism, and appendicitis? : \_\_\_\_\_  
OR  
(b) Any other disease or accident requiring confinement to bed and medical or surgical treatment? : \_\_\_\_\_
4. Details of Vaccination/Immunization : \_\_\_\_\_
5. Have you or any of your near relations been afflicted with tuberculosis, asthma, fits, epilepsy, insanity or birth defects? : \_\_\_\_\_
6. Have you suffered from any form of nervousness due to overwork or any other cause ? : \_\_\_\_\_
7. Have you been examined and declared Unfit for Government Service by a Medical Officer/Medical Board, within the last three years? : \_\_\_\_\_

8. Furnish the following particulars concerning your family:

Father's age if living and state of health	Father's age at death and cause of death	No. of brothers living, their ages and state of health	No. of brothers dead, their ages at death and cause of death
Mother's age if living and state of health	Mother's age at death and cause of death	No. of sisters living, their ages and state of health	No. of sisters dead, their ages at death and cause of death

9. Past Occupation :  
Give details of Name of the Company and Job Hazards if any.

\_\_\_\_\_

\_\_\_\_\_

10. Personal History

Diet : \_\_\_\_\_

Smoking : \_\_\_\_\_

Other Habits : \_\_\_\_\_

11. Marital Status :

Married/Unmarried: \_\_\_\_\_ No. of Children: \_\_\_\_\_

I declare all the above answers to be, to the best of my belief, true and correct.

I also solemnly affirm that I have not received disability certificate/pension on account of any disease or other condition.

Candidate's signature: \_\_\_\_\_ Signed in my presence: \_\_\_\_\_

Signature of  
Medical Officer: \_\_\_\_\_

**Note: The candidate shall be held responsible for the accuracy of the above statement. By willfully suppressing any information, he will incur the risk of losing the appointment or forfeiting all claims to superannuation allowance / gratuity, if appointed.**

FORM- 2

EXAMINING PHYSICIAN'S REPORT

1. PERSONAL DETAILS:

Name: \_\_\_\_\_ Sex: Male/Female  
Date of Birth: \_\_\_\_\_ Marital: Married/Unmarried  
Status  
Designation: \_\_\_\_\_ Division & Section: \_\_\_\_\_  
Nature of Job: \_\_\_\_\_  
\_\_\_\_\_

General Appearance: \_\_\_\_\_  
\_\_\_\_\_

Marks of Identification:

I. \_\_\_\_\_  
II. \_\_\_\_\_

Signature of Medical Officer: \_\_\_\_\_ Signature of Candidate: \_\_\_\_\_

2. HISTORY:

a) Personal : \_\_\_\_\_  
b) Family : \_\_\_\_\_  
c) Past History : Major Illness/Operations/Injuries with date  
\_\_\_\_\_  
\_\_\_\_\_

d) Occupational: Previous \_\_\_\_\_ Duration of year \_\_\_\_\_  
Type of work done \_\_\_\_\_  
(Details of past exposure to any significant occupational hazards)

e) Female Candidate:  
 Menstrual History:  
 i) Age at menarche: \_\_\_\_\_ ii) LMP: \_\_\_\_\_

iii) History of miscarriages/abortions/still births/congenital malformation etc.  
 \_\_\_\_\_  
 \_\_\_\_\_

3. GENERAL EXAMINATION:

a. Temperature : \_\_\_\_\_ °C      b. Pulse : \_\_\_\_\_

c. Height (in cms) : \_\_\_\_\_      d. Weight : \_\_\_\_\_ Kgs

e. Blood pressure : \_\_\_\_\_

f. Acuity of vision:

		Without glasses	With glasses	Strength of glasses		
				Sph	Cyl	Axis
Distant Vision	RE					
	LE					
Near Vision	RE					
	LE					

Note: Detailed visual acuity test to be performed specifically for personnel to be posted as Drivers, Crane operators, Fork-lift operations, Locomotion operations, Firemen, Security Personnel)

- Night Blindness : \_\_\_\_\_
- Colour vision : \_\_\_\_\_
- Depth of Vision : \_\_\_\_\_
- Fundus Examination : \_\_\_\_\_

Skin condition : Normal/ Abnormal Comment if any

Teeth : Normal/Abnormal Comment if any

Lymph nodes : Normal/Abnormal Comment if any

ENT : Normal/Abnormal Comment if any

Special Investigation

- i) Varicose Veins : \_\_\_\_\_
- ii) Deformities : \_\_\_\_\_
- iii) Hernia : \_\_\_\_\_
- iv) Hydrocele : \_\_\_\_\_
- v) Hemorrhoids : \_\_\_\_\_
- vi) Lymph nodes : \_\_\_\_\_
- vii) Oedema : \_\_\_\_\_
- viii) Fistula : \_\_\_\_\_
- ix) Thyroid : \_\_\_\_\_

**4. Systemic Examination:**

- a) Respiratory system : \_\_\_\_\_
- b) Cardiovascular system : \_\_\_\_\_
- c) Gastro-intestinal system : \_\_\_\_\_
- d) Locomotor system : \_\_\_\_\_
- e) Central Nervous system : \_\_\_\_\_
- f) Genito-Urinary system : \_\_\_\_\_
- g) Others : \_\_\_\_\_



FORM- 3

MEDICAL CERTIFICATE OF FITNESS FOR EMPLOYMENT

I hereby certify that I have examined Shri/ Smt. /Kum. \_\_\_\_\_  
a candidate for employment in the \_\_\_\_\_ Department  
and found him/her medically

- I. Fit
- II. Unfit on account of \_\_\_\_\_
- III. Temporarily Unfit on account of \_\_\_\_\_

His/ Her marks of identification:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

and Blood Group is \_\_\_\_\_

Medical Officer's  
Signature : \_\_\_\_\_

Name : \_\_\_\_\_

Designation : \_\_\_\_\_