SRFTI

MEDICAL CERTIFICATE

(to be filled by a registered medical practitioner[RMP] respecting the applicant)

(all names in BOLD and order of first name / middle name / surname)

FULL NAME: _____

Father's Name: _____

Mother's Name: _____

AGE: _____ DATE OF BIRTH: _____ SEX: _____ BLOOD GROUP: _____

DD / MM / YY

ADDRESS:

PIN: PHONE NO. b:
m:

HISTORY:

Mark the following with (+) for positive finding AND (-) for negative finding; mention how long ago was the occurrence.

DISEASE	FINDINGS	OCCURRENCE	DISEASE	FINDINGS	OCCURRENCE	DISEASE	FINDINGS	OCCURRENCE
Scarlet fever			Pneumonia			Ears tinitus		
Rhumatic fever			Tuberculosis			Otorrhoea		
Yellow fever			Cholera			Deafness		
Typhoid			Jaundice			Epistaxis		
Malaria			Diphtheria			Obstruction		
Encephalitis			Anaemia			Photophobia		
						Dim vision		
Cardiorespiratory			Vertigo					
Palpitation			Geng's headache			Venereal disease		
Short of breathe pain			Tension headache			Hansen's disease		
Chest pain			Nervousnes			Vitiligo		
Sweat			Epilepsy			Scabies		
Night sweat			Depression			HIV		
Tachycardia(type)			Paranoia			AIDS		
Hypertension								
Expectoration			congenital			Allergy		
Cough(acute/ chronic)			Metabolic (diabetes etc.)			Hormonal		
Haemoptysis						OTHERS		
Asthma								
INJURY			specify injury / operations			Period of disability	comments	
OPERATIONS								

SEE OVERLEAF

PHYSICAL EXAMINATIONS:

HEIGHT _____ WEIGHT _____

HEAD _____ NOSE _____ PHARYNX _____

NECK _____ CHEST _____ HEART _____

LUNGS(comment about air volume/entry)

EARS (provide audiometric test report to exclude deafness partial/otherwise; should be able to hear whisper from a distance of 30cm.)

EYES (provide test report of eyesight test for distant+near+colour vision)

BLOOD (comment on the clinical study especially for ESR/sugar/Hb)

General Remarks: (specify comments in case of physically challenged)

RECOMMENDATION: Based on the information & submission by the applicant and my physical & clinical findings following is my recommendation (TICK ANY ONE)—

A. This applicant presents no evidence of communicable diseases or of any fatigue and has no physical defects. I hereby certify that he/she is physically & mentally fit to carry on the course of study, involving long strenuous & stressful hours of work.

B. This applicant has a history of chronic ailment but can lead a normal life under routine medication. The ailment MAY / MAYNOT relapse under given regimen. The applicant has been briefed about the necessity & requirement of the regimen AND consequences thereof. I hereby certify that as long as he/she follows the regimen he should be able to carry on the course of study within a reasonable limit of strenuous & stressful hours of work.

C. This applicant has a history of neurological/other ailment due to which he/she MAY NOT be fit to carry on the course of study, involving long strenuous & stressful hours of work.

D. This applicant is physically challenged otherwise he/she presents no evidence of communicable diseases or of any fatigue. I hereby certify that with suitable arrangement he should be able to carry on the course of study suitable to him/her in terms of strenuous & stressful nature of work.

(IN BLOCK LETTERS)

SIGNATURE [RMP] FULL NAME[RMP]:

DATE PERMANENT ADDRESS[RMP] as in PAN:

REGISTRATION NO.

PHONE [RMP] b:

m: SEAL(if any):