

MEDICAL FORM

(Annexure to the Ministry of Health OM No. F. 5(II)-55-M. II Dated 27 Sept. 1957)

CANDIDATE'S STATEMENT / DECLARATION

(To be filled in the presence of the Medical Officer)

The candidate must make the statement required below prior to his/her Medical Examination and must sign the declaration appended thereto. His/Her attention is specially needed to the warning contained in the note below:-

1. State your name in full : _____
(IN BLOCK LETTERS)

2. State your Age and Place of birth : _____

3. a) Have you ever had small pox, intermittent or any other fever, enlargement or suppuration of glands, spitting of blood, asthma, heart disease, fainting attacks, rheumatism, appendicitis? : _____

Or

b) Any other disease or accident requiring confinement to bed and medical or surgical treatment? : _____

4. When were you last vaccinated? : _____

5. Have you or any of your near relatives been affected with consumption, scrofula, gout, asthma, fits, epilepsy, or insanity? : _____

6. Have you suffered from any form of nervousness due to overwork or any other cause? : _____

7. Have you been examined and declared fit 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

Mother's age, if living; and state of health	Mother's age at death and cause of death

No. of Brothers living, their Age and State of health	No. of Brothers dead, their ages at death and cause of death

No. of Sisters living, their Age and State of health	No. of Sisters dead, their ages at death and cause of death

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

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

(Candidate's Signature)

Signed in my presence

(Signature & Stamp of Civil Surgeon /District Medical Officer/C.M.O.)

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

FORM OF MEDICAL CERTIFICATE

I hereby certify that I have examined Sh./Smt./Km. _____
_____ a candidate for appointment in the
grade of _____ (name of Post) in AFHQ/ ISOs and cannot
discover that he/she has any disease (communicable or otherwise), constitutional
weakness or bodily infirmity except _____

I do not consider this a disqualification for temporary/permanent employment in
AFHQ/ISOs. Sh./Smt./Km. _____ 's age is,
according to his/her own statement _____
and by appearance about _____ years.

Dated : _____

(Signature & Office Stamp of
Civil Surgeon /District Medical Officer/C.M.O.)

Signature of the Candidate _____

Left Hand Thumb & Fingers impression:-

Thumb Fore-Finger Middle Finger Ring Finger Little Finger

To be filled up by candidate	
Rank No.	SL/
Exam's Name & Year	