

MEDICAL EXAMINATION FORM

Doc no :SRPL/SOP/006 , Rev no-00, Issue date:21-09-20

FORM XI

Certificate Sr.no:-----

Project:_____

Examining doctors name: _____ Date: __/__/_____ Time: _____

Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/Residence	Occupation/Designation

Medical and occupational history

Clinical Examination with particular reference to:

1. General Physique: Height & Weight: -----CM -----KG , BP----- Pulse Rate-----
2. Blood Group : ----- (Lab report must be attached)
3. Vision:
4. Hearing:
5. Breathing:
6. Upper Limbs:
7. Lower Limbs:
8. Spine:
9. Vertigo:
10. Epilepsy:
11. General (Mental alertness and stability with good eye, hand and foot coordination):

Any other tests which the examining doctor considers necessary.

I hereby certify that I have personally examined (name) son/daughter/wife ofresiding at.....who is desirous of being employed in building/Factory and construction work and that his/her age as nearly as can be ascertained from my examination is.....years and that he/she is fit for employment in.....as an adult/adolescent.

Reason for –

- 1.Refusal of certificate
2. Certificate being revoked.....

Signature/Left hand Thumb impression of worker

**Signature with Seal of Medical Inspector/C.M.O
Registration No:**

Note:

1. Exact details of cause of physical disability should be clearly stated.
2. Functional/productive abilities should also be stated if disability is stated.