



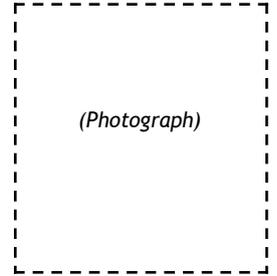
## Medical Fitness Certificate

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

Father's Name: \_\_\_\_\_

Gender: \_\_\_\_\_

Age: \_\_\_\_\_



1. Weight: \_\_\_\_\_ (kg) Height \_\_\_\_\_ (cm) BP \_\_\_\_\_

2. Blood group: \_\_\_\_\_ 3. Lungs: \_\_\_\_\_

4. Heart: \_\_\_\_\_ 5. Vision: Left Eye \_\_\_\_\_ Right Eye \_\_\_\_\_

Details of Glasses (if worn): \_\_\_\_\_ 6. Hearing: \_\_\_\_\_

7. Any Impediment in Speech: \_\_\_\_\_

8. Any Disability: \_\_\_\_\_

9. Any Neurological / Psychiatric disease, (if yes, please give details) \_\_\_\_\_

10. Suffering from Hepatitis B / Hepatitis C / HIV (AIDS) \_\_\_\_\_

11. Any significant Disease Diagnosed in the past: \_\_\_\_\_

12. Covid-19 Negative Report (Not older than 7 days) Either one from followings: -

- a. Covid-19 PCR                      b. Covid-19 Antibody                      c. Covid-19 Vaccination

13. Taking any medicine on regular basis (if yes, please give details) \_\_\_\_\_

14. Allergies if any: \_\_\_\_\_

15. Any Communicable / Contagious Disease: \_\_\_\_\_

16. Mark of Identification: \_\_\_\_\_

I certify that I have examined Mr / Ms \_\_\_\_\_

Son / Daughter of who is an applicant for admission to MBBS/BDS Program in Rahbar Medical & Dental College and could not notice that he / she has any physical or mental disease and is FIT for undertaking studies.

\_\_\_\_\_  
Signature of Doctor with legible seal  
PM&DC Regn No. \_\_\_\_\_

\_\_\_\_\_  
Signature of Candidate (In presence of Doctor)  
Dated: \_\_\_\_\_