MEDICAL REPORT

(To be certified by only Government hospital/clinic)

1. Full Name of Applicant :	
2. Age:	
3. Sex: (Male / Female)	
4. Height (cm):	
5. Weight (kg):	
6. Blood Group:	
7. Blood Pressure:	
8. Pre-prandial Blood Sugar:	
9. Post-prandial Blood Sugar:	
10. Is the person examined in good health at present?	
11. Is the person examined physically and mentally fit to carry out intensive training away from home?	Yes ☐ No ☐
12. Free of Infectious Diseases	Yes ☐ No ☐
13. Yellow Fever (If yes, please certify)	
14. Any chronic ailment which may require regular treatment/medication during the course? (If yes, please specify)	
15. Abnormalities indicated in the chest X ray (If yes, please specify)	
16. Does the person require any special assistance to carry out his daily activities? (If yes, please specify)	

Details of Doctor/Physician who have performed the test

Date of test report	
Name of Doctor/Physician	
Doctor Registration No.	
Doctor Address	
Doctor city	
Doctor Phone Number	☐ ☐ ☐
Doctor Email Id	

Signature of Doctor/Physician: _____ Seal of Government Clinic/Hospital: _____