**CANDIDATE’S STATEMENT AND DECLARATION**

**Faculty/SR/JR**

The candidate must make the Statements required below prior to his/her Medical Examination and must sign the Declaration.

Name in Full(In BLOCK LETTERS)……………………………………………………………..

Department …………………………………………. Designation ………………………….

1. Male - Female-
2. DOB: (DD/MM/YYYY)- / /
3. Name any major disease you have suffered from:……………………………………………...
4. Are you being treated for any disease at present: YES NO

If, YES- name the disease-

1. Have any of your near relations been afflicted with-

Insanity- YES / NO, Tuberculosis- YES / NO,Diabetes mellitus- YES / NO,

Allergic disorders,- YES / NO, Gout- YES / NO, Excessive bleeding- YES / NO

Relation-

1. Are you allergic to any substance /drug:……………………………………………………….
2. Have you been immunized against the mentioned diseases-
3. Hepatitis B: Yes/No
4. Polio: Yes/No
5. Diphtheria: Yes/No
6. Tetanus: Yes/No
7. Tuberculosis (BCG): Yes/No
8. Any Other Vaccination:………………………………………………………………

**Two Identification marks-**

1. **…………………………………………………………………………………………..**
2. **…………………………………………………………………………………………..**

All the above answers are true and correct to the best of my belief.

Date:

Candidate’s signature

**Note**: *The candidate will be held responsible for the accuracy of the above statement. By willfully suppressing any information will incur the risk of cancellation of admission.*

**CLINICAL EXAMINATION**

**Name of the Candidate:**

**MEDICINE**

**General Physical Examination** (Tick wherever appropriate)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **General Appearance (Built)** | **Good** |  | **Fair** |  | **Poor** |  |
| **Height (without shoes) (in cm)** |  |
| **Weight (without shoes) (in kg)** |  |
| **Pulse (rate/minute)** |  |
| **Blood Pressure (mmHg)** |  |
| **Oral Hygiene** | **Good** |  | **Fair** |  | **Poor** |  |
| **Skin (Any obvious disease)** | **Yes** |  | **No** |  |
| **Cyanosis** | **Present** |  | **Absent** |  |
| **Pallor** | **Present** |  | **Absent** |  |
| **Icterus** | **Present** |  | **Absent** |  |
| **Pedal Edema** | **Present** |  | **Absent** |  |
| **Clubbing** | **Present** |  | **Absent** |  |
| **Any obvious abnormality of the locomotor system** | **Yes** |  | **No** |  |

Systemic Examination:

**Remark- Fit /Unfit**

Other-

Consultant Signature (Stamp)

**SURGERY**

General examination-

Any Mass/ Lump-

**Remark- Fit /Unfit**

Other-

Consultant Signature (Stamp)

**Name of the Candidate:**

**OPHTHALMOLOGY**

**Vision**

|  |  |  |
| --- | --- | --- |
|  | **Visual activity** | **Color vision** |
| **Right** | **Left** | **Normal** | **Abnormal** |
| **Without glass** |  |
| **With glass** |  |

Near Vision:

Fundus (Undilated)-

**Remark- Fit /Unfit**

Other-

Consultant Signature (Stamp)

**E.N.T.(Otorhinolaryngology)**

**Ear:**

**Nose:**

**Throat:**

**Neck:**

**Hearing**

|  |  |  |
| --- | --- | --- |
|  | **Normal** |  **Abnormal** |
| **Left** |  |  |
| **Right** |  |  |

**Remark- Fit /Unfit**

Other

Consultant Signature (Stamp)

**OBSTETRICS & GYNAECOLOGY** (Applicable to women candidates only)

|  |  |
| --- | --- |
| **Any Gynecological Complaint** |  |

Cycle-

LMP-

**Remark- Fit /Unfit**

Other-

Consultant Signature (Stamp)

**Name of the Candidate:**

**For Hepatitis B Vaccination Details**

**HIC No…………………………….**

**Vaccinated for Hepatitis B Yes/No**

**If Yes: Number of doses taken (All three doses to be taken)……………………….**

**Anti HBs Antibody titer…………………………**

**If No: Advised to start Hepatitis B vaccine**

**If not taking Hepatitis B (Reason for refusal ……………………………**

**If refused declaration that I Mr./Ms. …………………………………is responsible for consequences of not taking vaccination/ not completing vaccination schedule for Hepatitis B.**

**Signature of ICNO Name & Signature**

**Stamp of HICT (Health care professional for Medical Examination)**

**(level-1 building 3 room no: G001) (Mon to Friday -02:30 – 03:30 PM)**

**INVESTIGATIONS**

**Name of Candidate- ………………………………………………………………**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **S.No.** | **Investigation** | **Reference no.** | **Report attached** **Y/N** | **Remarks** |
|  | Haemoglobin |  |  |  |
|  | Total Leukocyte Count |  |  |  |
|  | Differential Leukocyte Count |  |  |  |
|  | ESR |  |  |  |
|  | Urine routine examination/ME |  |  |  |
|  | Blood Grouping |  |  |  |
|  | Fasting Plasma Sugar |  |  |  |
|  | Serum Urea |  |  |  |
|  | Serum Creatinine |  |  |  |
|  | Liver Function Test |  |  |  |
|  | Lipid Profile |  |  |  |
|  | Serum Sodium |  |  |  |
|  | Serum Potassium  |  |  |  |
|  | G6PD |  |  |  |
|  | Chest X-ray |  |  |  |
|  | ECG |  |  |  |
|  | FEV1  |  |  |  |
|  | SPO2 |  |  |  |
|  | HIV |  |  |  |
|  | HBsAg |  |  |  |
|  | HCV |  |  |  |
|  | Urine for Pregnancy |  |  |  |

**Name of the Candidate:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Test** | **Report** | **Signature** |
| **HIV** |  |  |
| **HbsAg** |  |  |
| **HCV** |  |  |
| **U.P.T** |  |  |

**FINAL ASSESSMENT OF THE MEDICAL BOARD**

(The Board should record their findings under one of the following three categories)

1. Fit for pursuing the course: Fit Unfit
2. Unfit for pursuing the course on account of: .............................................................................................................................................................................................................................................................................
3. Temporarily unfit on account of:

………………………………………………………………………………………………………………………………………………………………………………………………

Date:

Dr. Manisha Naithani

Vice Chairperson Medical Board

AIIMS, Rishikesh

**Chairperson** **Medical Board**

Medical Superintendent

AIIMS, Rishikesh