

Medical Fitness Certificate

Name:				(Photograph)		
Father's Name:				, - 3 . ,		
CNIC:						
Age:					ļ	
1. Weight:	(kg)	Height:	(cm)			
2. Blood group:		3. Lungs (PFTs) :				
3. Vision: Left Eye	Righ	nt Eye Det	tails of Glasse	es (if worn):		
4. Hearing:						
6. Any Disability:	atric disease, (if yes	, please give details) (AIDS)				
9. Any significant Disease Di	agnosed in the past	t:			-	
10. Taking any medicine on re 11. Allergies if any:						
12. Any Communicable / Cont	agious Disease:					
13. I certify that (tick ✓ the re	elevant)					
a. I have not been teste b. If positive date of tes Duration of treatment from I certify that I have examined	Mr. / Ms who is an ap	to pplicant for admission at	Son/[: NUMS for (Certificate in Healt	hcare	
Signature of Doctor with legible seal PM & DC / PMC No:			Signature of Candidate (In presence of Doctor)			
		Signature of Candida				
CNIC	_					
Dated:		Dated:	Datea:			
_		ered Medical Practitioner on with other educational docu	=	time of admission		
-	For NUM	1S Use Only				
FIT		UN	IFIT			
mana anta:						
mments:					I	