Medical Fitness Certificate

(Photograph)

Name: _____

Father's Name: _____

CNIC: _____

Age: _____

1. Weight:_____(kg) Height:_____(cm)
2. Blood group:_____3. Lungs (PFTs) : _____
3. Vision: Left Eye ---------- Right Eye ---------- Details of Glasses (if worn): ----------
4. Hearing: .....
5. Any Impediment in Speech: .....
6. Any Disability: _____
7. Any Neurological / Psychiatric disease, (if yes, please give details). ----------
8. Suffering from Hepatitis B / Hepatitis C / HIV (AIDS) _____
9. Any significant Disease Diagnosed in the past: _____
10. Taking any medicine on regular basis (if yes, please give details). ----------
11. Allergies if any: - .....
12. Any Communicable / Contagious Disease: _
13. I certify that (**tick ✓ the relevant**)

    a. I have not been tested positive for COVID-19.
    b. If positive date of test _____

Duration of treatment from_____to_____.

I certify that I have examined Mr. / Ms. ----------Son / Daughter of ---------
---------- who is an applicant for admission at NUMS for Certificate in Healthcare Assistant 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	***Signature of Candidate (In presence of Doctor)***
PM & DC / PMC No:	
CNIC	
Dated:	***Dated:***

Note:

- **To be examined, signed and stamped by Registered Medical Practitioner only.**
- **Please submit Medical Fitness Certificate along with other educational documents at the time of admission**

For NUMS Use Only

FIT	**UNFIT**

Comments: _____

Date: _____ **Signature:** _____