



NTPC Limited
(A Government of India Enterprise)

DISCIPLINE : _____

DATE OF MED : _____

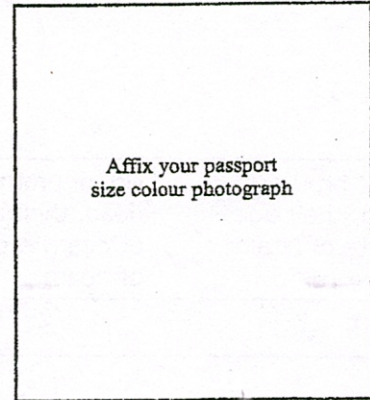
SL.NO.: _____

REG NO./ROLL NO : _____

MEDICAL EXAMINATION REPORT

(For use and retention in Medical Department)

PART-I



Ref. No. :

Age :

Date of Birth :

Post for which selected :

Name in full
(in block letters) :

Father/Husband's Name :

Address (Permanent):

Candidate's Statement & Declaration
(To be completed before the Medical Examination)

- (a) Have you ever had small pox, intermittent or any other fever, enlargement or suppuration of glands, spitting of blood, asthma, heart disease, lung disease, bronchitis, fainting attacks, rheumatism, appendicitis, night blindness ?
- (b) Any other disease of accident requiring confinement to bed and medical or surgical treatment ?
- (c) Did you suffer from any illness, wound or injuries sustained in the past with compensation paid if any ?
- (d) When were you last vaccinated ?
- (e) Have you or any of your near relations been afflicted with consumption, scrofula, gout, asthma, fits, epilepsy or insanity ?
- (f) Have you suffered from any form of nervous breakdown or mental illness?

(g) Furnish the following particulars concerning your family :

Father's age if living & state of Health	Father's age at death and cause of death	Mother's age if living & state of Health	Mother's age at death and cause of death
1	2	3	4

No. of brothers Living, their age & state of health	No. of brothers dead, their age at death & cause of death	No. of Sisters Living, their age and state of health	No. of Sisters dead, their age at death & cause of death
1	2	3	4

Note : The candidate will be held responsible for the accuracy of the above statement. By willfully suppressing any information he/she will incur the risk of losing the appointment and if appointed, of forfeiting all claims at Provident Fund/ Gratuity and other benefits.

I declare all the above answers to be, to the best of my knowledge, true and correct.

I certify that I have not received a disability certificate/pension on account of any disease or other condition.

Signed in my presence :

**SIGNATURE OF MEDICAL OFFICER
(NTPC)**

SIGNATURE OF CANDIDATE

Date

Date

PART-II

(To be recorded by the Authorized Medical Officer of NTPC)

- (a) **IDENTIFICATION MARKS** : 1.
2.
- (b) **APPEARANCE :**
- 1. Age : Years
 - 2. Physique : Well Built/ Thin Built
 - 3. Temperament : Sober / Nervous/Irritable
 - 4. Marks of Primary Vaccination : Present/Absent
 - 5. Operation Scars :
- (c) **HEIGHT, WEIGHT, CHEST :**
- Abdominal Growth
- 1. Height without shoes : Cms.
 - 2. Weight without shoes :Kgs.
- For male only :**
- 3. Chest in full expiration :Cms.
 - 4. Chest in full inspiration :Cms.
 - 5. Abdomen over naval-stripped :Cms.
- (d) **BODY MASS INDEX** :Kg/m²
- (e) **MOUTH, NOSE, EARS :**
- 1. Teeth : Clean/dirty/missing/dentures
 - 2. Gums : Healty/unhealty
 - 3. Tongue : Clean/ Coated
 - 4. Nose : Normal/ Congested/ Tonsile
 - 5. Hearing : RE : Normal/ Impaired
LE : Normal/ Impaired
 - 6. Tympanic membrane : RE : LE :
 - 7. Ear discharge : Yes/No Other abnormality
- (f) **GLANDS** : Thyriod

(g) EYES :

- | | | | | |
|-----|---|---|---------|------|
| 1. | Distant Vision | : | RE : | LE : |
| 2. | Distant Vision With glasses | : | RE : | LE : |
| 3. | Near Vision | : | RE : | LE : |
| 4. | Strength of glasses used | : | Reads : | |
| 5. | Contact Lenses | : | | |
| 6. | Whether Suffering from squint or any other morbid condition of the eyes or eyelids. | : | | |
| 7. | Field of Vision | : | | |
| 8. | Colour Vision | : | | |
| 9. | Fundus examination (if indicated) | : | | |
| 10. | Any other defects | : | | |

FIT / UNFIT

Counter Signature of MO/
Eye Specialist with date

(h) CHEST

Normal/ Deformed

- | | | | |
|----|-----------------------|---|--|
| 1. | Form | : | |
| 2. | Lungs | : | |
| 3. | Respiration | : | |
| 4. | Cardio Vacular System | : | |

(i) HEART :

- | | | | |
|----|----------|---|--|
| 1. | Size | : | |
| 2. | Position | : | |
| 3. | Rate | : | |
| 4. | Sound | : | |

(j) ECG

(k) BLOOD VESSELS :

- | | | | |
|----|--------------------------|---|------------------------------------|
| 1. | Pulse in upper and lower | : | |
| 2. | Blood Vessel | : | Normal/ Thickened/ Varicose/ Veins |
| 3. | Blood Pressure | : | Systolic/ Distolic mm of Hg. |

(l) ALIMENTARY SYSTEM :

1. Liver :
2. Spleen :
3. Abnormalities (i.e., piles)
Fistula, Peptic ulcer, etc.) :

(m) GENITO URINARY SYSTEM :

1. Urine :
 - (a) Specific / Gravity
 - (b) Albumin - present / Absent
 - (c) Sugar - Present / Absent
 - (d) Microscopic
Present / Absent
2. Hernia :
3. Evidence of VD :
4. Scrotum : Normal / Hydrocele / Bubonecele/
Varicocele / other
5. Testicles : Normal / Undescended

SURGICALLY FIT / UNFIT

(n) NERVOUS SYSTEM :

1. Mental Condition :
2. Reflexes :
3. Pupils :
 - (a) Normal / Abnormal :
 - (b) Light reflex
Present / Absent :
4. Specify any other evidence of
Disease of nervous system except
Epilepsy viz. paralysis, wasting,
Tremors, irregular movements etc. :

(o) REPRODUCTIVE SYSTEM :

(For female candidates)

1. History of menstrual cycle : Regular / Irregular
2. Breasts :
3. Pregnancy with duration :
4. Local/ P.V. / P.S. Examination
(if required) :

(p) INVESTIGATIONS :

1. Blood Examination
 - (a) Routine :
 - (b) Group :
 - (b) Blood Sugar : Fasting :..... PP :.....
2. Stool :
3. Sputum (if required) :
4. Skiagram Chest :
5. Skiagram Chest :

Certified that Shri/ Smt./ Km.....

A candidate selected for the post of.....

Whose signature/ thumb impression is appended below is medically

FIT / UNFIT / TEMPORARILY UNFIT

**Signature/ Thumb Impression
of candidate**

AUTHORISED MEDICAL OFFICER

Signed before me
AUTHORISED MEDICAL OFFICER

Countersigned

CHIEF MEDICAL OFFICER

Note : Time extension of maximum period of 21 days may be given to temporarily unfit cases.



NTPC Limited
(For retention in Human Resource Department)

CONFIDENTIAL

SL. NO. : _____

DISCIPLINE : _____

DATE OF MED : _____

Post for which selected _____

Affix your passport
size colour photograph

**MEDICAL CERTIFICATE OF FITNESS ON FIRST
ENTRY INTO COMPANY'S SERVICE**

1. I hereby certify that I have examined Shri/ Smt. / Km.....
Son/ Daughter/ Wife of Shri a candidate for the
post of and could not discover that he/ she has any
disease (communicable or otherwise) except I do/
do not consider this as a disqualification for employment in the company. I. therefore, certify that this
candidate is medically **Fit/ Unfit/ Temporarily Unfit.**
2. Shri/ Smt./ Km age according to his/ her own statement
is.....Years and by his/ her appearance about.....years.
3. Identification marks (as recorded in the medical examination forms)
(a)
(b)

Signature of the candidate

MEDICAL OFFICER

Note/ Remarks if any

Counter Signed by
Chief Medical Officer

