DOW UNIVERSITY OF HEALTH SCIENCES
SCHOOL OF POSTGRADUATE STUDIES

MEDICAL FITNESS

Note: Section A, B, & C will be filled by the candidate.

SECTION A

Name: ____ S/o, D/o ____

Age: ________________ Days ____________________ Months ___________________ Years ________________

Height: ____ Weight: ____

Present Address: ____

SECTION B

1. Do you smoke? .... (Yes) (No)
2. Do you take any medicine regularly .... (Yes) (No)
   If yes, Specify____
3: Any history of allergy .... (Yes) (No)
4. Do you suffer from any of the following diseases? .... (Yes) (No)
   - i. Epilepsy .... (Yes) (No)
   - ii. High Blood Pressure .... (Yes) (No)
   - iii. Psychiatric Illness .... (Yes) (No)
   - iv. Rheumatic Heart Disease .... (Yes) (No)
   - v. Diabetes... (Yes) (No)
   - vi. Hepatitis B/C .... (Yes) (No)
   - vii. Physical Disability it malignancy .... (Yes) (No)

   If yes, Specify____

SECTION C

Details of previous Vaccination	Detail of Booster Vaccination
1. Measles .... Yes	No ....
2. Mump .... Yes	No ....
3. Rubella .... Yes	No ....
4. Tetanus .... Yes	No ....
5. Pertussis .... Yes	No ....
6. Whooping Cough .... Yes	No ....
7. Hepatitis .... Yes	No ....
8. Tuberculosis .... Yes	No ....
9. Any other .... Yes	No ....

Current COVID-19 test report before joining the department. **Yes / No.**

Certification: Hereby certify that the above information given by me is correct.
The trainee is fit to perform duties.

____

Verified by a PMDC Registered Practitioner
(Stamp with PMDC Number)

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Trainee's Signature
with name