Annexure-1

ARMOURED VEHICLES NIGAM LIMITED AMBARNATH
(MACHINE TOOL PROTOTYPE FACTORY AMBARNATH)

PRE-APPOINTMENT MEDICAL EXAMINATION

Candidate's personal declaration:

(To be filled in by the candidate with the assistance of hospital staff assigned for the purpose)

Please answer all questions honestly, accurately and completely. If you do not understand any question, please seek clarification from the examining medical officer or staff designated to assist you. The information provided regarding your medical history and health habits will be used to make a careful medical assessment of whether you can safely and efficiently perform the essential functions of the job for which you are a candidate and will not necessarily disqualify you from employment. Detailed medical information will be treated confidentially.

Please note that furnishing of false information or suppression of any factual information would be a disqualification for the job and will render the candidate unfit for any employment under the Government. If the fact that false information has been furnished or that there has been suppression of any factual information comes to notice at any time during the service of a person, the candidate's services would be liable to be terminated.

Candidate's personal information :

Paste photo of the candidate here. To be attested by the MO carrying out the medical examination

1. Post for which the candidate has been Offered appointment.
2. Name in full (In block letters) (last,first,middle):

   _____
3. Date of Birth: _____
4. Age : _____yrs(In completed years)
5. Sex : Male/Female
6. Marital Status : Married/Unmarried

Contd..2/-

Health questionnaire :

Do you now have or have ever had any of the following conditions?

(Strike out whichever is not applicable)

1	High Blood pressure	Yes	No		28	Giddiness/fainting	Yes	No
2	Heart/blood vessel disease	Yes	No		29	Loss of consciousness	Yes	No
3	Irregular heart rhythm	Yes	No		30	Severe/frequent headaches	Yes	No
4	Abnormal ECG	Yes	No		31	Speech disorder	Yes	No
5	Varicose veins	Yes	No		32	Balance problem	Yes	No
6	Chest pain	Yes	No		33	Stroke, aneurysm or bleeding in head	Yes	No
7	Breathlessness	Yes	No		34	Paralysis or muscle abnormality	Yes	No
8	Leg swelling	Yes	No		35	Any other neurological abnormality	Yes	No
9	Leg pain on walking	Yes	No		36	Mental illness	Yes	No
10	Asthma	Yes	No		37	Depression	Yes	No
11	Tuberculosis	Yes	No		38	Attempted suicide	Yes	No
12	Cough > 1 month	Yes	No		39	Eye/vision problem	Yes	No
13	Coughing up of blood	Yes	No		40	Need for corrective lenses?	Yes	No
14	Blood disorder/anaemia	Yes	No		41	Deficiency of co lour vision	Yes	No
15	Abnormal blood clotting	Yes	No		42	Oral health problems	Yes	No
16	High or low blood cell counts	Yes	No		43	Digestive problem	Yes	No
17	Enlarged spleen	Yes	No		44	Difficulty in swallowing	Yes	No
18	Diabetes	Yes	No		45	Blood in motion	Yes	No
19	Thyroid or other endocrine problem	Yes	No		46	Frequent or persistent stomach pain	Yes	No
20	Kidney problem	Yes	No		47	Frequent or persistent vomiting	Yes	No
21	Urine problem	Yes	No		48	Vomiting of blood	Yes	No
22	Skin problem	Yes	No		49	Jaundice	Yes	No
23	Infectious/contagious diseases	Yes	No		50	Hernia	Yes	No
24	Genital problems	Yes	No		51	Piles	Yes	No
25	Pregnancy	Yes	No		52	Motion problems	Yes	No
26	Frequent or persistent sleep problems	Yes	No		53	Liver, pancreas or gall bladder disease	Yes	No
27	Epilepsy/fits	Yes	No					

Contd..3/-

54	Ear/nose/throat/sinus problems	Yes	No
55	Hearing deficiency	Yes	No
56	Hoarseness of voice	Yes	No
57	Joint problems/Restricted mobility	Yes	No
58	Back problems pain	Yes	No
59	Amputation	Yes	No
60	Fractures/dislocations	Yes	No
61	Any pins, plates or screws in legs or feet?	Yes	No
62	AIDS, HIV infection or hepatitis	Yes	No
63	Significant injuries	Yes	No

64	Loss of weight > 5kg in last 6 months	Yes	No
65	Medical treatment in past 12 months	Yes	No
66	CT scan, MRI or other special tests	Yes	No
67	Loss/excess of appetite > 1 month in last 6 months	Yes	No
68	Fever last one month	Yes	No
69	Frequent or persistent itching	Yes	No
70	Organ transplant	Yes	No
71	Cancer or tumour	Yes	No

72	Have you ever had any operation ?	Yes	No
73	Have you ever been hospitalized ?	Yes	No
74	Are you aware that you have any medical problems, diseases or illnesses?	Yes	No
75	Are you allergic to any drug, food or other substances ?	Yes	No
76	Any health problem, which requires visits to doctor, or for which you take regular drugs?	Yes	No

If any of the above questions were answered “yes”, please give details by referencing item number. Provide information regarding diagnosis and treatment, including dates of treatment. Please use additional sheet (s), if necessary.

Are you taking any drugs?	Yes	No

If yes, please list the medications taken and the purpose (s) and dosage(s).

Contd..4/-

For Female Candidates only :

(Strike out whichever is not applicable)

Menstrual History

Age at which first menses occurred: yrs

Duration of menstrual period : days.

Quantity : Norma//clots/profuse/scanty

Pain during menses : YES/NO

Menstrual cycles : Regular/Irregular

Duration of menstrual cycle : days

Last menstrual period began on:

Obstetric History

Number of pregnancies :

Live births:

♦Normal delivery :

♦Caesarean :

♦ Forceps :

Still birth :

Abortions :

Occupational History:

(Strike out whichever is not applicable)

77	Have you ever been exposed to fumes, dust, chemicals, asbestos, loud noise or radiation at work or elsewhere?	Yes	No
78	Have you ever received worker's disability/compensation?	Yes	No
79	Have you been absent from work of medical reasons in the past five years ?	Yes	No
80	Have you ever required light or restricted duty ?	Yes	No
81	Have you ever had any occupational injury	Yes	No

If any of the above questions were answered "yes", please give the details by referencing item number. Please use additional sheet(s), if necessary.

Do you use : (Strike out whichever is not applicable)

	Now		In past		Details
Cigarettes	Yes	No	Yes	No	
Tobacco	Yes	No	Yes	No	
Alcohol	Yes	No	Yes	No	
Drug	Yes	No	Yes	No	

Contd..5/-

Family medical history :

Have your father, mother, any brother or sister had or has the following condition?
(Mark Yes/No)

Asthma	Yes	No
Allergic disease	Yes	No
Epilepsy	Yes	No
High Blood pressure	Yes	No
Diabetes	Yes	No
Heart disease	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Tuberculosis	Yes	No
Any other chronic or serious disease	Yes	No

If any "yes" answer, please give details by referencing item number
If father, mother, any brother or sister is not alive, their age and cause of death

Immunisation status :

Tetanus prophylaxis status:

□ **Total ≥ 3 injections & last < 10 yrs**

□ **Total ≥ 3 injections & last < 10 yrs**

□ **Total < 3 injections**

Others: (e.g. hepatitis B for health workers)

Past medical examinations:

1. Have you been examined by a Medical Board before? Yes/No

2. If answer to the above is YES, please state

   a) What service/services you were examined for?

   b) Who was the examining authority?

   c) When and where was the Medical Board held?

   d) Results of the Medical Board's Examination if communicated to you or if known.

Contd..6/-

I hereby certify that all the above answers are, to the best of my knowledge and belief, true and correct.

Candidate's Signature

Signed in my presence

(Signature of MO)

Date :

(Name & designation (seal)

Health advice given:

Additional history recorded by medical officer:

Contd..7/-

PROFORMA FOR PRE-EMPLOYMENT MEDICAL EXAMINATION REPORT

ARMOURED VEHICLES NIGAM LIMITED AMBARNATH
(MACHINE TOOL PROTOTYPE FACTORY AMBARNATH)
PRE-APPOINTMENT MEDICAL EXAMINATION

Ref: The requisition for medical examination No……. dated…….

Name of the post:

Name of the candidate:

Personal Identification marks of the candidate:

1._____

2._____

The photo of the candidate to be pasted and attested by the MO carrying out the medical examination

☐ Initial examination

☐ Re-examination (refer our previous report dated_____)

Report:

I hereby certify that I have evaluated the above certificate for medical fitness for employment in Machine Tool Prototype Factory, Ambarnath on the above post on the basis of the information provide regarding working conditions and the requirements of physical abilities for the post candidate's personal declaration, my clinical examination and investigation results and accordance with standing instructions of Ordnance Factory Board. On the basis of above evaluation, my opinion regarding the medical fitness of the candidate for the above post is:

☐ Fit
Description of restrictions/required aids, if any:

☐ Unfit

☐ Temporarily of unfit for a period of _____

Date :

Signature of the M.O :
Name of MO :
Designation of MO :

I acknowledge that I have been advised of the content of the medical examination form.
I consent to the release of medical information under description of restrictions/aids required about me given above.

Signature of the Candidate :_____

(To be signed in the presence of examining medical officer)