## **MEDICAL FITNESS CERTIFICATE**

## (To be filled in by Registered Medical Practitioner in BLOCK LETTERS)

I certify that I have on this (date)day following person:	of (month), 200 medically examined the
Name:	Son/Daughter/Wife of
and/or student of (	institution name)
Age: Weight:	Pulse Rate: Blood Pressure:
Blood Test: Blood Group:	
Note: Applicant shouldn't be suffering from As hernia and chronic diseases.	thma, Epilepsy or other fits, and any major deformity,
	whose signature is given below is DA12 being organized by Indian Railway Catering and
Tourism Corporation Limited, North Zor (Duration)Days	ne, Delhi (Date from)
Participant's Signature:	
House Address:	
Govt. ID proof type	ID proof no
Medical Practitioner's name (in BLOCK LETTERS):	
Seal/Stamp:	
Medical Practitioner's signature:	Registration no
Address:	
Date:	Place:

**Note:** The medical practitioner should at least be an M.B.B.S. and provide the registration no. of Medical Council of India.