

Medical Examination of Candidates for Employment by Government

CONFIDENTIAL

G.P. 62

Medical Officer -in- Charge (Hospital) _____

The bearer *Mr/Mrs/Miss _____ has been selected for

appointment as _____ in the _____
of the Public Service subject to being medically fit. Kindly forward report in duplicate on this form to the Head of the Department recruiting officer.

Signature _____ Designation _____ Date _____

NOTE TO MEDICAL OFFICER. For unestablished and temporary candidates only this side should be completed and x-ray check taken.

NOTE TO CANDIDATES: You Should (i) Make appointment with the sister-in-charge of the clinic before going for examination.
(ii) Take stool and urine samples on first visit.

A. To be completed by the candidate:

Surname _____		Forenames _____
Date of birth: _____	Marital Status: _____	No. of Children: _____

B. To be completed by the Medical Officer from answers given by the candidate:

(i) Have you suffered or are suffering from:—

1. Enteric Fever (Typhoid) _____ *YES/NO
2. Dysentery or Chronic Diarrhoea _____ YES/NO
3. Malaria _____ YES/NO
4. Venereal Disease _____ YES/NO
5. Rheumatic Fever _____ YES/NO
6. Heart Disease _____ YES/NO
7. Tuberculosis _____ YES/NO
8. Rupture _____ YES/NO
9. Kidney Disease _____ YES/NO

10. Chest Complaint (if yes, details please) _____ YES/NO
11. Diabetes _____ YES/NO
12. Hypertension _____ YES/NO
13. Asthma _____ YES/NO
14. Discharge from ear or deafness _____ YES/NO
15. Leprosy _____ YES/NO
16. Epilepsy or fits _____ YES/NO
17. Insanity, mental instability, nervous breakdown or disorder _____ YES/NO
18. Any other serious or chronic disease: (if yes, details please) _____ YES/NO

(ii) Have you met with any serious accident or personal injury or have had a surgical operation. *YES/NO (if yes, details please)

(iii) What is the present general state of your health: _____

(iv) L.N.M.P. _____

(v) Are you predisposed to any complaint? *YES/NO (if yes, details please): _____

C. State the following particulars regarding your parents:

	IF LIVING		IF DEAD	
	AGE	STATE OF HEALTH	AGE	CAUSE OF DEATH
FATHER				
MOTHER				

I hereby declare that I have carefully considered the statements made above, that to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement and I give my consent to the examining or assessing medical officer to communicate with any physician who has attended me.

Signature of candidate _____

Witness _____
(Examining Officer)

Date _____

*Delete where in applicable