

FORM-V
(rule-6)
HEALTH EXAMINATION
(Except mine employees)

PART –A (Sl.No.1-11) : To be filled by the Employee:

1. Name of employee.....

2. Sex.....

3. Age (with DOB).....

4. Company.....

5. Designation.....

5a. UAN:.....

6. In-charge Employer / Executive Contacts.....

7. Complete personal /plant Address

8. Mobile /Phone

9. Email.....

10. Medical illness (Current) and under treatment & medication, If any.....

.....

11. Nature of Job (furnish more details, if hazardous and work-related viz. Physical, Chemical, Biological, Ergonomic etc)
.....

Date:

Signature of Employee

PART-B:

12. Medical Test Carried out & Reports to be Attached as Annex . Medical Officer's interpretation/ Opinion of the Tests below (To indicate only if abnormal , referring the attached Test reports) :

- a. Ht. Wt. Chest, Waist Circumference, Body Mass Index:
- b. Vision (Ophthalmologist tests):
 - i. Visual Acuity both Right & left eyes
 - ii. Colour Vision.....
- c. Blood Pressure
- d. Complete Blood Count:
- e. Blood Sugar (Fasting/PPBS/HbAC1).....
- f. SpO₂.....
- g. Blood Urea Nitrogen (BUN).....
- h. SGOT/SGPT.....
- i. Lipid profile.....
- j. ESR.....
- k. Thyroid profile.....
- l. X-ray Chest etc.....
- m. ECG.....
- n. Others if any.....

13. Final Diagnosis/ Opinion / Treatment if any, advise by qualified medical practitioner

14. Does the person has seizure (s) related disorders or difficulties working at Height? If yes, explain the works to be avoided:
Yes/No/ NA (Not applicable)

Date:

Signature of the qualified medical practitioner

SEAL

NOTE: All the above information is highly confidential between the Applicant and the Examining Physician. Sharing of the above with Employer or any other agency/persons is permitted only on obtaining Consent from the Applicant/Employee.