## **MEDICAL FITNESS CERTIFICATE**

| NAME of candida                         | te:  |  | Age:                           | Sex:                 |              |
|---|--|--|--------------------------------|----------------------|--------------|
| General Examina                         | tion :-  |  |                                |                      |              |
| Weight                                  | :  |  |                                |                      |              |
| Height                                  | :  |  |                                |                      |              |
| Pulse rate                              | :  |  |                                |                      |              |
| Blood Pres                              | sure :   |  |                                |                      |              |
| EYE SIGHT                               | :  | Acuity :   | Acuity : Good/ Fair / Poor     |                      |              |
|   |  | Color vision:  | Good/ Fair                     | / Poor               |              |
| HEARING:                                |  | Right Ear :  | Good/ Fair                     | / Poor               |              |
|   |  | Left Ear :   | Good/ Fair                     | / Poor               |              |
| any infectious sk<br>course of study ir | in disease<br>n Hospitalit   | r examination I find that I<br>and is fit to perform all<br>by and Hotel Administration<br>opping of all vegetables; | practical classes as me<br>on. |                      |              |
|   | Cooking in kitchen;  |  |                                |                      |              |
|   | All work in bakery and Confectionary;                                    |  |                                |                      |              |
|   | Service of Food and Beverages; Floor moping, handling of vacuum cleaner; |  |                                |                      |              |
|   | omputer o  |  | icunci,                        |                      |              |
|   |  |  | (Signature of                  | Registered Medical F | Practitioner |
|   |  |  |                                | Seal                 |              |
|   |  |  | Registration No                | o:                   |              |