Annexure-I

CERTIFICATE OF PHYSICAL FITNESS

(To be filled by a Registered Medical practitioner in the applicant's country of domicile)

Name of Applicant _____

Sex M/F _____

Marital Status _____

Age _____ Blood Group _____

Nationality _____

Address _____

(City) _____

(Country) _____

Telephone No. _____

Email Address _____

I. **Medical History** (Please give details of any past medical condition which may adversely impact the patient's health at the current time or in the near future).

IA. **History of Any Known Illness / Surgery:-**

Raised BP -	Yes ☐	No ☐	If, yes – on Regular treatment -	Yes ☐	No ☐	
DM -	Yes ☐	No ☐	If, yes – on Regular treatment -	Yes ☐	No ☐	
IHD -	Yes ☐	No ☐	If, yes – on Regular treatment -	Yes ☐	No ☐	
Stroke -	Yes ☐	No ☐	If, yes – on Regular treatment -	Yes ☐	No ☐	