

FORM-VIII
(See rule 5(2))
HEALTH EXAMINATION
 (Except mine employees)

photo

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

1. Name of employee.....2. Gender.... 3. Age (with DOB).....
4. Company..... 5.Designation.....5(a). UAN:..... 5(b) Aadhaar Number (after obtaining consent)
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.....
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11. Nature of Job (furnish more details, if hazardous and work-related viz. Physical, Chemical, Biological, Ergonomic etc)

- Date: _____ Signature of Employee _____
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PART-B:

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

- a. Ht. (in cm)
- b. Wt. (in Kg)
- c. Chest measurement:

- (i) On inspiration cm
- (ii) On expiration cm
- (d) Waist Circumference
- (e) Body Mass Index:
- (f) Vision (Ophthalmologist tests):
 - i. Visual Acuity both Right & left eyes
 - ii. Colour Vision.....
- (g) Blood Pressure (mm Hg).....
- (h) Complete Blood Count: (Hb, TLC, DLC, Platelets).....
- (i) Fasting Blood Sugar
- (j) Post Prandial Blood Sugar.....
- (k) SpO₂.....
- (l) Blood Urea
- (m) S. Creatinine
- (n) S. Bilirubin (Total + direct)
- (o) SGOT
- (p) SGPT.....
- (q) Lipid profile (S. Cholesterol / Triglyceride / S.HDL)
- (r) S. TSH
- (s) X-ray Chest (PA view)
- (t) ECG.....
- (u) Others if any.....

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

14. Does the person have seizure (s) related disorders or difficulty in working at height ? If yes, specify the works to be avoided: Yes/No/ NA
(Not applicable)

Date:

Signature of the qualified medical practitioner

SEAL