Reformed & Presbyterian Seminary

Lalitpur, Metropolitan City, Ward-25 Postal Address: GPO 8975, EPC 1923,
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Medical Report

Date……./……./……

To be completed by the applicant

Full Name: ……....

Date of Birth: …… Sex: …… Marital Status: ……

If Married?

No. of Children ……..

Names	**Age:**
1. ……	……
2. ……	……
3. ……..	……

Home Address:

……

……

Family History: List the illness or causes of death of;

Parents:

……

Brothers/Sisters:

……

Wife/Children:

……

Signature of the applicant

Form 4: *Medical Report Form*

To be completed by the applicant's doctor

Does the candidate have any physical deformities/limitations or serious medical concerns? If yes, please provide specific details.

Please indicate if the candidate suffers from any of the following conditions by ticking the appropriate options:

□ Poor vision
□ Eye strain
□ Poor hearing
□ Noises in ears
□ Frequent headaches
□ Frequent colds
□ Nose bleeds
□ Bleeding gums
□ Sinus trouble
□ Allergies
□ Shortness of breath
□ Asthma
□ Bronchitis
□ Palpitation of heart
□ Skin disease
□ Food intolerance
□ Uric acid
□ Stomach problems
□ Mental depression
□ Sleep trouble
□ Other medical problems

Please mark all applicable conditions, if any.

Medical Advice or Medications Suggested:

……..

Doctor's Signature Seal

Form 4: *Medical Report Form*