Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

## FORM XI

	2.4	LOKI	1 (3)			
Certificate Sr.no:						
Project:Ample						
Examining doctor's	name: D.	Arvivoth	Date: 2	0/08/2	023 Time: 10.3	D AM
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
Praveen Kuman	Jayaraman	08/05/1988	A mole in	M	vergedosamuthisam Dharmapubli TN-636905	Sr. Enginee
Medical and occup	ational history					
Clinical Examinati	on with particular	reference to:		1	and the c	<b>P</b> .
1. General Phy	sique: Height & W	eight:CM	87 KG, BP	0/70	- Pulse Rate	min
2. Blood Group	o: Otre (Lab	report must be at	tached)			
3. Vision: (1						
4. Hearing: (	. 8					
5. Breathing: (						
6. Upper Limb						
7. Lower Limb	,					
8. Spine: (N						
9. Vertigo: ( N			View No.			
10. Epilepsy: (	N .					
	ental alertness and s	tability with good	d eye, hand and fo	oot coor	dination): ( N)	
Any other tests wh						
being employed in being employed in being examination is adult/adolescent.  Reason for –  1. Refusal of certifica	mmresionulding/Factory andyears	ling at	m! Involuerk and that his/he he is fit for e	er age as	s nearly as can be as	s desirous of certained from as a
2. Certificate being re			······································		K	
Signature/Left hand impression of work	l Thumb			N	ignature with Scal of Icdical Inspector/C. legistration No:	.M. O

Note:

1. Exact details of the cause of physical disability should be clearly stated.

2. Functional/productive abilities should also be stated if disability is stated.

Dr. D. ARVINTH, Mpre Reg. No: 1410a. Medcare Hospital Mathur, Oragadam

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

### FORM XI

Project: Amplus solar  Examining doctor's name: D. Arvinth Date: 20/08/2023 Time: 10, 30 am  Name Father's Name Date of Identification Sex Address/ Occup	
10002033	
Name Father's Name Date of Identification Sex Address/ Occup	
Birth/Age Marks Residence Design	
Alex Pandiyan Rajagopal 13/07/1994 A mole in right side M Tuticorn. Senie (29) Chest TN-628 502 Techn	
Medical and occupational history	
Clinical Examination with particular reference to:	
1. General Physique: Height & Weight: 172 CM 88.9 KG, BP Pulse Rate Pulse Rate	
2. Blood Group: - AB+10 (Lab report must be attached)	
3. Vision: (N)	
4. Hearing: (N)	
5. Breathing: (N)	
6. Upper Limbs: (N)	
7. Lower Limbs: (N)	
8. Spine: ( H )	
9. Vertigo: (ん)	
10. Epilepsy: (N)	
11. General (Mental alertness and stability with good eye, hand and foot coordination): (N)	
Any other tests which the examining doctor considers necessary.	
I hereby certify that I have personally examined (name)	fron is ai
2. Certificate being revoked.	
Albarandium	
Signature/Left hand Thumb  Signature with Seal of	
impression of worker  Medical Inspector/C.M. O Registration No: 141048	

## Note:

- 1. Exact details of the cause of physical disability should be clearly stated.
- 2. Functional/productive abilities should also be stated if disability is stated.

Pr.D.ARVINTH, More, Aeg. No: 1470.

		FORM	IXI			
Certificate Sr.no:	0.3				4.	
Project: Amplus	Solar				*	
Examining doctor's		Avvinta	Date: 20	2/08/20	23 Time: 16.30	AM
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
rignesh	Perigasany	05/08/1999	on left hand	M	Seelanayanjatti,	Technician
Medical and occupa	ational history	(24)			TN-636 006	
Clinical Examination	on with particular	reference to:		1		1 -
1. General Phys	sique: Height & We	eight: 168_CM	42.4 KG, BP	mofic	m Mey 85	1/mm
2. Blood Group	: Btre (Lab	report must be at	ttached)			
3. Vision: (r		,	,			
4. Hearing: (					,	
5. Breathing: (	/					
6. Upper Limbs						
7. Lower Limbs						
8. Spine: (N	)					
9. Vertigo: (N						
10. Epilepsy: (						
	ntal alertness and s	tability with good	d eve hand and fo	not coor	dination):	
					dination). C 7	
Any other tests whi	ich the examining	doctor consider	s necessary.			
I hereby certify that  Leave and being employed in bu my examination is. adult/adolescent.  Reason for –  1. Refusal of certificat	illding/Factory and years	and that he/s	rk and that his/ <del>he</del> he is fit for e	er age as employn	s nearly as can be as nent in. Sky fri.	certained from
2. Certificate being re	voked		······			
Signature/Left hand impression of worke				N	ignature with Scal of ledical Inspector/C degistration No:	.M. O
Note: 1. Exact details of the 2. Functional/product				d.	D.ARVINTH,	Mebs.,

		FORM	<u>1 XI</u>			
Certificate Sr.no:	04					
Project: Amplu	s solar					
Examining doctor's	name:	Arvivith	Date: 2	0.68/2	023 Time: 10.30	am
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
vijay Kumar	Sahgamitssad	01/02/2004	A mole on Left hand	M	Kohjhar, Kushuhagar,	Associate Technician
Medical and occupa	ational history				1017-214 203	TELAMORA
Clinical Examination	on with particular	reference to:		1	Ala.	, I
1. General Phys	sique: Height & We	eight: 171 CM	66-1, \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	obon	- Pulse Rate	min
2. Blood Group	: Btre (Lab	report must be at	ttached)		. also rate	
- 3. Vision: (7			,			
4. Hearing: (	/					
5. Breathing:	,					
6. Upper Limbs						
7. Lower Limbs						
8. Spine: ( )	(14)					
	,					
9. Vertigo: (٨)						
		ali:11:4	1			
	ntal alertness and st			oot coor	dination): ( A)	4:
Any other tests whi	ch the examining	doctor consider	s necessary.			
I hereby certify that  being employed in bu my examination is. adult/adolescent.  Reason for -  1.Refusal of certificate	Play 2001resid inding/Factory and years	construction wo	rk and that his/he he is fit for e	r age as	nearly as can be as	s desirous of certained from as a
2. Certificate being re-						
Signature/Left hand impression of worker	Thumb			Si N	ignature with Scale ledical Inspector/C egistration No: 14	.M. O
Note: 1. Exact details of the 2. Functional/producti	cause of physical d	lisability should lalso be stated if a	be clearly stated.		D. P ARVINTH	

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

### FORM XI

Certificate Sr.no: C	25					
Project: Ang	lux solar					
Examining doctor's r	name:D.	Arriva	Date: 2	0/08.	2023 Time: 10.30	AM
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
Madesany	Intam	17/09/1996	A mole in well hand	М	ventadaralazura Thodhukudi. TN-628 502	*Associate Technician
Medical and occupa	tional history					
Clinical Examinatio	n with particular	reference to:	100	-1	mm lh .o.	1
Clinical Examinatio  1. General Physics	ique: Height & W	eight: 170 CM	KG, BP	10/90	Pulse Rate	win
2. Blood Group:	Btve (Lab	report must be a	ttached)			
3. Vision: (N	4					
4. Hearing: (						
5. Breathing:	/					
6. Upper Limbs:	- 1					
7. Lower Limbs	200					
8. Spine: (N)	,					
9. Vertigo: (N						
10. Epilepsy: ( n						
_		tability with goo	d eye, hand and fo	oot coo	ordination): (N)	
Any other tests which						
			·			
I hereby certify that I  being employed in bui my examination is adult/adolescent. Reason for -  1.Refusal of certificate  2. Certificate being rev	ilding/Factory and	ding at	ork and that his/he	er age a	ment inSRU.	s desirous of scertained from as ar
12 2			***************************************		10	
Signature Left hand	Thumb				XIC	
impression of worker					Signature with Scal Medical Inspector/C	
					Registration No: 14	

Exact details of the cause of physical disability should be clearly stated.
 Functional/productive abilities should also be stated if disability is stated.

Dr.D.ARVINTH, MRSS., Reg. No: 141606 Medeare Hospital Watnur, Oragagam

		<u>FORM</u>	<u>1 XI</u>			
Certificate Sr.no:	08					
Project: Amplw	solar					
Examining doctor's	name:	wrinth	Date: 2	1/08/20	23 Time: 10.30	AM
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupatio Designation
velayutham	Ravi	27/03/1996	A mole on left hand	M	Keelakudigicupin Ariyalare, TN - 621 802	Technicia
Medical and occupa	ational history					
Clinical Examination	on with particular	reference to:	60 11	nland	mm Ha and	-0110
1. General Phys	sique: Height & Wo	eight: 143_CM	63 KG, BP	0110	nm Hg 90/	
2. Blood Group	: A ve (Lab	report must be at	tached)			
3. Vision:	)					
4. Hearing: ()						
5. Breathing: (	/					
6. Upper Limbs						
7. Lower Limbs						
8. Spine: ( N )						
9. Vertigo: (N						
10. Epilepsy: (N	20					
	ntal alertness and st	ability with good	eve, hand and fo	ot coord	dination):	
Any other tests which						
being employed in bumy examination is adult/adoleseent.  Reason for –  1.Refusal of certificate	ilding/Factory and2.7years	construction wor and that he/sł	k and that his/ <del>he</del> he is fit for er	Fage as	nearly as can he asc ent in. Sky. Dr.	certained from
2. Certificate being rev	voked			•••••	10	
Volocyushom Signature/Left hand					XC	
impression of worker				M	gnature with Seal o edical Inspector/C. egistration No: )ム	M. O
Note: 1. Exact details of the case of the				. R	D.ARVINTH, M leg. No: 14104 edcare Hospit Mathur, Oragadan	is tal

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

		FORM	1 XI			
Certificate Sr.no:	.09					
Project: Am?	lus solar					
Examining doctor's	name:	hvinth	Date: 2	1/08/20	3 Time: 10.30	MA
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
ABINASH	Raviehandian	16/11/2001	Acut scar on left hand	M	Chidambaram Cuddalore TN-608 001	Associal
Medical and occupa	ational history					
2. Blood Group 3. Vision: (N 4. Hearing: (n 5. Breathing: 6. Upper Limbs 7. Lower Limbs 8. Spine: (N 9. Vertigo: (N) 10. Epilepsy: (1)	sique: Height & We Btve (Lab ) (N) (N) (N) (N) (N)	eight: 175-CM report must be a	ttached)		nm Hy = 19. Pulse Rate	min
Any other tests whi						
I hereby certify that  Line Mixed being employed in bu my examination is adult/adolescent.  Reason for —  1. Refusal of certificate	ilding/Factory and 23years	and that he/s	rk and that his/he he is fit for e	r age as	s nearly as can be as nent in. Sky or	certained from
2. Certificate being re- Signature/Left hand impression of worker	Thumb			Si M R	ignature with Seal of Iedical Inspector/C legistration No:   4 <sub>1</sub>	.м. о 048
Note: 1. Exact details of the 2. Functional/producti	cause of physical d	lisability should also be stated if	be clearly stated. disability is stated	II.	D.ARVINTH, MI eg. No: 14104 deare Hospit	BBS., 8 a1

Mathur, Oragadam

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

			FORN	1 XI			
Certificate	Sr.no:	13					
Project:	Amplus.	solar					
Examining	doctor's i	name:	Arvinth	Date: 2	0/08/2	023 Time: 10.30	an
Nan	ne	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
Maria A	Intony	John Basco	13/09/1999	Scar on fore hoad	M	Madha Rottai Thayairus TN-613005	Sabety Execut
Medical a	nd occupa	ntional history				- ALL	dr. Su.
Clinical E	xaminatio	on with particular	reference to:	71 1.		and He To	lacina
1. Ge	neral Phys	ique: Height & Wo	eight:CM	KG, BP	10/80	nm Hg 78 - Pulse Rate	TAT VIAN
2. Blo	ood Group:	Btra (Lab	report must be at	tached)			
3. Vis	sion: (N	1)					
4. He	aring: (r	1)					
5. Bre	eathing: (	(h					
1	per Limbs						
Į.	wer Limbs	- /					
8. Spi	ine: ( N )						
9. Ve	rtigo: (N	)				1	
1	ilepsy: (N		12-				
1	_	ntal alertness and s	tability with good	l eye, hand and fo	oot coor	dination): (A)	
		ch the examining				-	
		_					
being emplo my examir adult/adoles Reason for 1.Refusal of	ohnBe oyed in but nation is seent. - f certificate	ilding/Factory and	ling at\2 construction wo and that he/s	rk and that his/he	er age as	son/den son/den who is nearly as can be asonent in Sky. Fri	desirous of certained from as a
2. Certificat	te being re	voked				-10	
€ A						X	
Signature/						ignature with Scal o	
impression	of worker	r				Iedical Inspector/C. Legistration No: 4	-
Notes						) . D. (	i i

Note:

1. Exact details of the cause of physical disability should be clearly stated.

2. Functional/productive abilities should also be stated if disability is stated.

Pr.D. ARVINTH, Moss, Reg. No: 1410e mare Hospital Wichnur, Oragadaiii

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

## FORM XI

ertificate Sr.no:	lus solar					
Name	Father's Name	Date of Birth/Age	Identification	Sex	Address/ Residence	Occupation Designation
SOYOVONA RELIMAY ·	To rue		Marks ABOUS FOREWARD	male	So Noeum	Designation  ASSOCIA  Hefter
<ol> <li>Blood Group</li> <li>Vision: E</li> <li>Hearing:</li> <li>Breathing:</li> <li>Upper Limb</li> <li>Lower Limb</li> <li>Spine: N</li> <li>Vertigo:</li> <li>Epilepsy:</li> <li>General (Me</li> </ol>	sique: Height & Wo p: (Lab 32 6 6 Normal BAE D ss: ] wormal os:	tability with good	tached)		Pulse Rate-	∩ <b>→</b>
I hereby certify that M. N. C.	I have personally  Lanceresionally  resionally  resionally  resionally  resionally  resionally  resionally  resionally  resionally  resionally  resionally	examined (name ding at	c) Salaway Mollumotica rk and that his/her ne is fit for en	r age as	nearly as can be asc ent in. Darnling	certained from
2. Certificate being r	evoked	······································	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	••••••		
Signature/Left hand impression of work				0.3. He	VEEN KUMA Scallo Glical Inspector C. Bistorio 1802 Nac	225
Note: 1. Exact details of th 2. Functional/produc	e cause of physical a tive abilities should	disability should l		Stiper	umbudar- 502 105	jai,

			FORM	1 XI			
	Certificate Sr.no;						
	Project: Am Aug		of school or any and a separate of the second second second second second	and the same of the authorized Specialists.			
	Examining doctor's	name: Dr.S.1	vavænku	man/ Date: +	6109 2	3 Time: 9.0	to Am.
The second secon	Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
	SABAPI VEL.	Katiya montu	y 29/12/1998	Almen Cherr.	male	88 peleanuly	· Solay.
	Medical and occupa	itional history					
	2. Blood Group 3. Vision; P. 4. Hearing; N. 5. Breathing; 6. Upper Limbs 7. Lower Limbs 8. Spine; P. 9. Vertigo; V. 10. Epilepsy;	ique: Height & We : (Labr 2 6/b. 201 mef BAZ (D). : Notine No. : Nom Nom Nom Nom Nom Nom Nom Nom	ight: 175 CM. report must be att	ached)		myPulse Rate - & ?	bpm.
	Any other tests which hereby certify that I La	have personally every residual ding/factory and control of the con	xamined (name) ng at	School state and that his her is fit for em	Pr Sign	" W. Orantia	MBBS.
	(Torstional/productive		so be stated if dis	ability is stated.	in particle		

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

## FORM XI

Certificate Sr.no: -	22					
Project: Amp	Ul Solar					
Examining doctor's	name: Dr. Wo	iveen tur	Date:	6/9/2	3 Time:	<u>M</u>
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation/ Designation
KPLYHNA KUM AP	Inrman provad	01/01/2003	Bon in Civer.	Male	Er Meum	. Associate Helpen
Medical and occup	ational history					
<ol> <li>Blood Group</li> <li>Vision:</li> <li>Hearing:</li> <li>Breathing:</li> <li>Upper Limb</li> <li>Lower Limb</li> <li>Spine:</li> <li>Vertigo:</li> <li>Epilepsy:</li> </ol>	rique: Height & Webs. ———— (Lab R666 L666 right right & Webs. ————————————————————————————————————	eight: -L66-CM report must be at	tached)	mm	<b>(+)</b>	colbm
Any other tests wh			high	make	ing/ ?	
being employed in bomy examination is adult/adolescent.  Reason for —  1. Refusal of certifications.	M. Leffresion in the control of the control o	ding at	ork and that his/h	er age a employi	s nearly as can be a	agas an
2. Certificate being re Signature/Left hand impression of worke	l Thumb			Dr.	S. NAVEEN KUMA Signature vijti sea Medical ligspervak Seejstration Noor-	R. M.B.B.S., 999 1061 GAM OTTOS.
Note: 1. Exact details of the 2. Functional/product	e cause of physical tive abilities should	disability should I also be stated if	be clearly stated disability is state			

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

## FORM XI

Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
Fredrick Grillin	Forgatuman		o trasm	male	Canchicen	Arroca m Help
Medical and occup			gove			
<ol> <li>Blood Grou</li> <li>Vision: [</li> <li>Hearing:</li> <li>Breathing:</li> <li>Upper Limb</li> <li>Lower Limb</li> <li>Spine: [</li> <li>Vertigo: [</li> <li>Epilepsy: [</li> </ol>	MORMAL BAZED 105: Justif. 105: Justif.	report must be at	tached)			
	ental alertness and st			ot coordin	nation):	
hereby certify that hereby certify that he hereby certification is a constant of the hereby certification in the hereby certification is desirable.	I have personally grace residuilding/Factory and when years	examined (name) ing at	Predictal MINOPANA c and that his/her e is fit for em	ploymen	arly as can be as	25,25 2
Signature/Left hand mpression of works Note:	l Thumb	inability ob a 14 b	phy of the second	Dr. S Sign:	NAYEEWKUMA algrowith Sent in Angletonica in Mallada in Mallada	Eusas.

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

## FORM XI

Certificate Sr.no:	27					
Project:		and the state of t	Maria Carlo Ca			
Examining doctor's	name: Dr 181	Navan ke	onay Date: H	6 109	18 Time: //.!	50 Am.
Name	Father's Name	Date of Birth/Age	Identification Marks	and the same of the same	Address/ Residence	Occupation Designation
Greraselbar	Pan.	20/03/1970	Appr in	male	Harunin drain	Helper
Medical and occupa	ational history			Political politi		
3. Vision: 8 4. Hearing: 6. Breathing: 6. Upper Limbs: 7. Lower Limbs 8. Spine: 6. Vertigo: 7. Vertigo: 7. Vertigo: 7. Vertigo: 7. Lower Limbs 9. Vertigo: 7. Vert	se blo soruf sosto				nyPulse Rate	(1) m
being employed in bui my examination is adult/adolescent. Reason for — 1.Refusal of certificate 2. Certificate being rev Signature/Left hand T impression of worker	have personally of the personally of the personally of the personally of the personal of the p	examined (name) ng atconstruction work and that he/she	Cllnowl Palem b and that his/her is fit for em	Signa Medi	VAVERNIKSHIAA, I ANA NA	M.B.B.S.,
1. Exact details of the co	ause of physical dis	sability should be	clearly stated.	Sri	perumbudur- 602	109.

2. Functional/productive abilities should also be stated if disability is stated.

2

S in

No 1. 2.

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

## FORM XI

Certificate Sr.no:	26					
Project: pmp/	us Solar					
Examining doctor's	name: DYS.	Navoen lee	Date: 1	5/09/-2	3_ Time://6	30.
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation Designation
yuvaraj	Solchalingun	1/04/1992	Ausin Jorehard	male	Tharuniraum	Helper
Medical and occup	ational history	•	0		-	
Clinical Examination	on with particular	reference to:	A.	ı. b.	2 01	1/5.
1. General Phys	sique: Height & We	eight: CM		Molk	Pulse Rate-91	11m
	o: (Lab	report must be at	tached)			
3. Vision:	eble.					
4. Hearing:	normal					
5. Breathing:	Mm.					
6. Upper Limbs	5: Tamo					
7. Lower Limbs	s: 1017 -					
8. Spine: M	m					
9. Vertigo: M	9					
10. Epilepsy:						
11. General (Mei	ntal alertness and st	ability with good	eye, hand and foo	ot coordi	nation):	
Any other tests whi	ch the examining o	loctor considers	necessary.	H		
	V.1		11011 705			
I hereby certify that  Limit L	ilding/Factory and	ing atconstruction work	k and that his/her e is fit for en	age as r	nearly as can be ascent	as an
2. Certificate being re-						
Signature/Left hand impression of worker  Note:  1. Exact details of the 2. Functional/production		isability should be	e clearly stated	SiRge	AVEEN KUMAR, M Balling with Seglight By This postor Kan Othan Balling Nadar Na Ushan Budur- 602 10	B.B.S., I. O Igar, 5.

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

Certificate Sr.no:		FORM XI						
Project:								
	Examining doctor's name: D. Arvinth Date: 18 10,2023 Time: 12.17 pm							
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation/ Designation		
Athash. M	Murigan	01/10/2001	AMde OVER	М	Tirwallury			
Medical and occupa	ntional history		(E) FOIZZATIIL.		TOTAL			
3. Vision: No 4. Hearing: No 5. Breathing: 0 6. Upper Limbs 7. Lower Limbs 8. Spine: No 9. Vertigo: No 10. Epilepsy: No	Clab  Consol  Consol	report must be at	tached)		nm Hy 68 - Pulse Rate  dination): Now			
I hereby certify that  I hereby certificate being revered to the certificate  I hereby certificate	I have personallyresiding/Factory and2.2years  voked  Thumb  cause of physical of	examined (name ling at	e)Akask wallwy. Tamor rk and that his/he he is fit for e	er age as imploym Si M R	nearly as can be as	of		

Dr.D.ARVINTH, MBBS., Reg. No: 141048 Wedcare Hospital Wathur, Oragadam

Doc no: M+/HSE/4054, Rev no-00, Issue date:21-09-20

		FORM X1				
Certificate Sr.no:						
Project:						
Examining doctor's	name:D	Arvioth	Date: 18	1012	023 Time: 12.1=	1 bm
Name	Father's Name	Date of Birth/Age	Identification Marks	Sex	Address/ Residence	Occupation/ Designation
Agithikann. V	Vanntash	26/11/1999	Ascor orol Ohnol.	M	Tiruvallus,	
Medical and occupa	ntional history					
Clinical Examination 1. General Phys	ique: Height & We	eight: 179-CM	92.4 <sub>KG, BP</sub>	60 n	nm Hy 6	b/min
1	_A+ve(Lab	report must be a	ttached)			
3. Vision: No	rml					
4. Hearing: N	lomel					
5. Breathing:	Normal					
6. Upper Limbs	Normal					
7. Lower Limbs	: almal					
8. Spine: No	ml					
9. Vertigo:	Marral					
10. Epilepsy:	•					
		tability with good	d eye, hand and fo	ot coo	rdination): Hosma	J
Any other tests which						
being employed in bu my examination is adult/adolescent. Reason for -	ilding/Factory and	ling at	rk and that his/he	r age a	who is nearly as can be as	s desirous of scertained from
1 Refusal of certificate	e					

Signature/Left hand Thumb impression of worker

2. Certificate being revoked.....

V. Azithher.

Note:

- 1. Exact details of the cause of physical disability should be clearly stated.
- 2. Functional/productive abilities should also be stated if disability is stated.

Signature with Seal of Medical Inspector/C.M. O Registration No: 141048 of of

Dr.D. ARVINTH, MEES. Reg. No: 141048 Meacare Hospital Wathur, Oragadam