



THE UNITED REPUBLIC OF TANZANIA  
 MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,  
 GENDER, ELDERLY AND CHILDREN



**TENGERU INSTITUTE OF COMMUNITY  
 DEVELOPMENT**

**MEDICAL EXAMINATION FORM  
 TO BE COMPLETED BY MEDICAL OFFICER**

**PERSONAL DETAILS**

1. FULL NAME OF TRAINEE:.....
2. SEX:  
 MALE/FEMALE:.....
3. AGE (Give date of birth).....
4. SEX .....
5. MARITAL STATUS:.....
6. PROGRAMME SELECTED.....

**MEDICAL INFORMATION**

- I. HB TEST : .....
- II. STOOL:.....
- III. URINE  
 MIRCO:.....
- IV. T.B TEST:.....
- V. EYE  
 EXAMINATION:.....
- VI. E.N.T:.....
- VII. CHEST:.....
- VIII. CHEST X-  
 RAY:.....
- IX. ABDOMEN:.....
- X. Total count (WBC).....
- XI. Differential count.....lymphocytes.....  
 monocytes.....basophils.....Neutrophils.....Eosinophil.....

**ADDITIONAL INFORMATION**

Physical Defects of Impairments, Infections, Chronic, or Hereditary (family) Disease.

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 .....

I certify that I have examined the above mentioned Candidates and consider that he/she is physically/not physically fit for training.

NAME ..... STAMP .....

DESIGNATION .....

DATE:.....

SIGNATURE.....