

## ANNEXURE-II

### MEDICAL CERTIFICATE (to be produced at the time of admission)

Certified that, I Dr. \_\_\_\_\_ (Reg. No. \_\_\_\_\_), have  
this day of \_\_\_\_\_ 2025 examined the candidate, whose particulars are given  
below:

1. Name of the Candidate :
2. Name of the Parent :
3. Sex : Male / Female
4. Age : \_\_\_\_\_ years and \_\_\_\_\_ months
5. Date of Birth :

|                                                |                                                |                                                |
|------------------------------------------------|------------------------------------------------|------------------------------------------------|
| Day                                            | Month                                          | Year                                           |
| <div style="width: 30px; height: 30px;"></div> | <div style="width: 30px; height: 30px;"></div> | <div style="width: 30px; height: 30px;"></div> |

6. Identification marks 1.
- 2.

7. Whether the Candidate  
fulfils the Following  
standards :

**Normal**

**If No, specify the defect**

**(a) General Fitness consists of**

- |                                     |                                     |
|-------------------------------------|-------------------------------------|
| Full Blood Test including HIV Test: | <b>Yes / No</b>                     |
| Full Urine Test :                   | <b>Yes / No</b>                     |
| Chest X-ray :                       | <b>Yes / No</b>                     |
| ECG :                               | <b>Yes / No</b>                     |
| Mental Retardness Test and :        | <b>Yes / No Other General Tests</b> |

- |                          |                 |
|--------------------------|-----------------|
| (b) Vision :             | <b>Yes / No</b> |
| (c) Auditory functions : | <b>Yes / No</b> |
| (d) Speech functions :   | <b>Yes / No</b> |

8. Whether differently abled : **Yes / No** (If **Yes**, specify the  
defect and the (Physically  
Handicapped) extent of  
disability)

- (i) Vision
- (ii) Speech
- (iii) Hearing
- (iv) Limbs

9. **OPINION:** with the above clinical details: **Yes / No**

Please specify, whether the candidate is physically eligible to be considered for admission in Tamil Nadu Dr. J. Jayalalithaa Fisheries University, Nagapattinam (If **No**, specify the reasons)

**Signature of the Candidate**

**Signature of  
Regd. Medical Practitioner**

Place:

Register No:

Date:

Full Address