OFFICE OF THE COMMISSIONER OF POLICE::DELHI

POLICE HEADQUARTERS, JAI SINGH ROAD, NEW DELHI 110001
ROOM NO. 911, TOWER-I, 9TH FLOOR: Email:recruitmentcell.splcell@delhipolice.gov.in
No. 2861 /Rectt.Cell(AC-I)/PHQ dated Delhi, the 17/07 /2026

PUBLIC NOTICE

Subject:- Regarding Proposal for Amendment in Rule 24 read with Appendix XXX of Delhi Police (Appointment & Recruitment) Rules.

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The Govt. of NCT of Delhi has sent the draft Recruitment Rules for amendment in Rule 24 read with Appendix XXX of Delhi Police (Appointment & Recruitment) Rules regarding medical examination of candidates for the posts in Delhi Police for inviting objections on the proposal, if any.

Therefore, the draft amendment in Rule 24 read with Appendix XXX of Delhi Police (Appointment & Recruitment) Rules is being uploaded on the official website of Delhi Police for information of all stakeholders. All stakeholders are requested to go through the draft Recruitment Rules and furnish their objection/comments, if any, to the undersigned within a period of 30 days i.e. date of its uploading on the website. In case, no objection/comments received as on date, the Delhi Police will proceed further for taking necessary action for amendment of aforementioned draft Recruitment Rules. No objections shall be entertained after the expiry of the stipulated period.

(Darade Sharad Bhaskar) IPS
Deputy Commissioner of Police,
Recruitment, Delhi

DRAFT

TO BE PUBLISHED IN THE GAZETTE OF INDIA: EXTRAORDINARY [PART II-SEC, 3(I)]

MINISTRY OF HOME AFFAIRS

NOTIFICATION

NEW DELHI, the March 2026

G.S.R. (E) - In exercise of the powers conferred by sub-section (1) and (2) of section 147 of the Delhi Police Act, 1978 (34 of 1978), the Lieutenant Governor of the National Capital Territory of Delhi is pleased to make the following rules further to amend the Delhi Police (Appointment & Recruitment) Rules, 1980, namely:

1. Short title and commencement	(1) These rules may be called the Delhi Police (Appointment and Recruitment)(Amendment) Rules, 2026
2. Amendment of rule 24:-	In Delhi Police (Appointment and Recruitment) Rules, 1980 for rule 24, the following shall be substituted, namely:-

24. Medical examination of candidates.-(1) Before enrolment, every candidate shall be medically examined and certified physically fit for police service by the medical officer. A certificate, in form Annexure-III' & Annexure-'IV' duly signed by the medical officer, is essential for enrolment. Before his/her medical examination the candidates shall be required to give a declaration in form Annexure-II in the presence of the medical officer such declaration being a precondition for enrolment. The candidates declared medically unfit shall be informed, in writing, of the reasons of unfitness.

(2) The medical examination for various posts shall be conducted as per standards and procedure laid down in amended Rule-24 read with amended Appendix XXX based on Committee report, containing 69 pages.

(3) For appointment in Delhi Police, the candidates should be of sound state of health, free from defect/deformity or disease. The medical officer shall test the candidate as per amended Rule-24 read with amended Appendix-XXX the overall health of the candidate including eye sight, speech and hearing which should be free from any defect and which can render him/her unfit for police service.

(4) **Persons with Disabilities candidates for the posts of ASI(Stenographer), HC(Ministerial) and HC(Store Clerk):** Locomotor disabilities 40% and above (Either one or both leg affected) shall be allowed. Their post is civilian in nature and they will not wear uniform of Delhi Police. The other medical requirements/conditions shall be as per the amended Appendix XXX.

(5) The appointing authorities may themselves reject candidates whose general standards of physique and intelligence are not satisfactory.

(6) In the case of women recruits, the medical examination shall be conducted by an approved lady Medical officer.

(7) The blood group of every candidate will be recorded for proper blood grouping so that the same could be made available to them in case of any medical emergency without any loss of time.

2. Amendment in Appendix XXX:-	In Delhi Police (Appointment and Recruitment) Rules, 1980 for rule 24, the following shall be substituted, namely:-
The medical examination for various posts in Delhi Police shall be conducted as per amended Rule-24 read with amended Appendix XXX.	

By order and in the name of the
Lieutenant Governor of the
National Capital Territory of Delhi,

Special Secretary (Home),
Govt. of NCT of Delhi.

REPORT

of

THE COMMITTEE

on

AMENDMENTS OF MEDICAL STANDARDS OF RECRUITMENT RULES, APPENDIX XXX READ WITH RULE 24 OF DELHI POLICE (APPOINTMENT & RECRUITMENT) RULES, 1980

CONTENTS

1. INTRODUCTION

A below mentioned committee was constituted by order of Commissioner of Police, Delhi to study in-depth the existing medical standards for recruitment to various posts in Delhi Police and give suggestions to amend the same, keeping in view the present-day requirements.

Sh. Ajay Chaudhry, Spl. CP/AP Div. & SPUW/AC/SPUNER	Chairman
Sh. Asif Mohd. Ali, Joint Director /DPA	Member
Sh. Satya Vir Katara, Addl. CP/Recruitment	Member
Dr. Rajneesh Garg, DCP/Licensing	Member
Sh. Johny Anto, ACP/ Rectt./PHQ	To assist the committee
SI (Min.) Rohit Kumar, Rectt. Cell/PHQ	To assist the committee
WPSI Divya Dagar, No. 3418/DPA	To assist the committee

The need for the same was felt acutely during the recent Mission Mode Recruitment of more than 10,000 candidates of Constable (Exe.), HC(AWO/TPO), HC(Ministerial) and Constable (Driver). There is a lot of ambiguity in the rules and procedures for conducting medical examination which has not been elaborately laid down and the same leads to confusion and gives scope for malpractices. The mandate of the Committee was as follows:

- To look into the discrepancies/deficiencies/anomalies/shortfalls in the existing Recruitment Rules and guidelines for medical examination mentioned in Appendix XXX read with Rule 24 of Delhi Police (Appointment & Recruitment) Rules, 1980.
- To frame rules for medical examination for the various posts in Delhi Police.
- To lay down clear-cut and elaborate rules and procedure to conduct medical examination in view of the present-day requirements.

Meetings held on the following dates:

i. 11 March, 2024
ii. 19 March, 2024
iii. 02 April, 2024
iv. 08 May, 2024
v. 14 May, 2024
vi. 16 May, 2024
vii. 28 May, 2024
viii. 30 May, 2024
ix. 06 June, 2024 (Final draft approved)

During these meetings, the committee elaborately deliberated on all aspects of medical examinations. The guidelines followed by other State police like Tamil Nadu, Uttar Pradesh, Rajasthan, Haryana etc. were also taken into account. The medical criteria of CAPFs were also looked into thoroughly.

Although the committee itself consisted of one medical doctor in Dr. Rajneesh Garg, DCP/ Licensing, albeit before finalizing the report, doctors from Delhi Administration and CAPF hospitals were also consulted for providing

reasoned inputs and problems being faced due to ambiguous rules and guidelines.

In conclusion, the committee constituted to amend the medical standards for recruitment in the Delhi Police, has meticulously prepared this report after extensive consultations with state police departments and paramilitary forces. By integrating insights from these consultations and analysing future needs and best practices from various forces, the committee has made comprehensive recommendations that address existing and anticipated challenges. These amendments are designed to enhance the operational readiness and resilience of the police force to ensure that the recruitment standards remain robust and adaptive to future demands. The proposed changes reflect a commitment to maintain a healthy, capable and responsive police force that can effectively serve and protect the community. The report hereby proposes amendments in Recruitment Rules for recruitment in all posts in Delhi Police henceforth.

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2. UNIFORM GUIDELINES FOR MEDICAL EXAMINATION FOR RECRUITMENT IN DELHI POLICE

I. General instructions for Recruitment Board

a. The medical examiner, while conducting medical examination of a candidate, if finding the candidate to be unfit, would record the parameter with reference where-to unfit has been opined. A reference would be made to the requisite standards prescribed or known to be prescribed and accepted as such by the experts in the field. This particular instruction should be strictly adhered to. For example, in case of unfitness due to tachycardia, it should be written as pulse rate 110/min (Normal range-60-100/min) or carrying angle 18 (Normal range-10 to 15).

b. Cause of rejection should be mentioned with reference to its location, size, side of the body and other parameters as per applicability. Minor acceptable defects will also be written in the appropriate paragraph of the form, with opinion of the medical examiner that the defect is not likely to interfere with the efficient performance of the duties which will be required of the candidate.

c. Medical examiner will put his signature, name, rubber stamp, date and place of medical examination at relevant paragraphs in the Medical Examination Booklet.

d. Measurement of physical standards viz. height, weight and chest is the responsibility of the PE&MT Board. Medical examiner will not be part of PE&MT board both for male and female candidates. Since presence of a female is required at the time of recording of physical standard, a female non-medical staff may be associated with PE&MT board. Medical examiner need not record the physical measurements. He will mention physical standard in the medical examination form as recorded by the PE&MT board. In borderline cases of overweight, BMI should also be considered to arrive at conclusion and variation of 5Kg +/- from the minimum/maximum limit may be accepted. Standard height-weight chart is attached at **Annexure-I**.

e. Identification marks should be noted concisely and clearly. Ideally, two identification marks are to be noted by the medical examiner. These should be of a durable nature, preferably on a visible/exposed part of the body and not on the limbs if possible. Very distinctive, marked/big features, if available, should be used. The two marks should be on different parts of the body. Identification marks should be mentioned with precise parameters as under:

    i. Side of the body. Eg- Right/Left, Front/Back etc.

ii. Distance from nearby landmark, distance from spine in case of upper back.

iii. Direction from nearby or underlying landmark, e.g. front/back/tip of shoulder, anterolateral to right nipple, 3 o'clock position for abdominal mark etc.

iv. Size and shape of the mark when applicable, e.g. birth mark, scar etc.

v. Colour of the mark if distinctive, e.g., in case of mole.

vi. As far as possible, high sounding/ medical terminology should not be used.

f. Ideally, all investigations are to be conducted at the Central Government/State Government/CAPFs Hospitals or their empanelled private institutions, failing which, services of non-empanelled private laboratories may be availed after observing proper codal formalities as per GFR.

g. Human body may contain so many defects/deformities that it is not possible to list all causes of unfitness in the medical recruitment instructions that may militate against efficient discharge of service. Neither is it possible to list all trifling cases where the candidate may be accepted/rejected. Therefore, the medical examiner needs to use his clinical acumen, to the best of his knowledge and keeping in view the best interests of the force. If the cause of rejection is not mentioned in these instructions, it has to be co-related to an infirmity with reference to either known medical literature on the subject or a parameter set out. In case of unfitness, where no known references are available the defect/infirmity may be elaborately justified with reference to service requirement for which the candidate is being rejected.

h. A declaration, as given in **Annexure II**, is to be obtained from the candidate regarding history or presence of diseases and treatment taken if any, evidence of which is not readily obtainable during the detailed medical examination. Any false declaration in this aspect, discovered later at any stage of service, will make the candidate liable for disciplinary action including termination of service. An undertaking to this effect will form part of the declaration.

i. Refusal to undergo medical examination at any stage or absenting oneself from the same will render the candidate unfit.

j. Medical examination should be conducted in a quiet, well lit and ventilated room having sufficient space.

k. One trained and experienced paramedical/nursing staff should be associated to assist the Medical Examiner. A ministerial staff should invariably be deputed by concerned administrative authority to provide secretarial assistance to the recruiting medical board.

l. All candidates who are subjected to medical examination will be examined thoroughly to assess their mental and physical fitness to perform all types of duties.

m. At some stages of medical examination male candidates are required to be examined in nude. Loin cloth is to be permitted except for, when genitalia and perineum is being examined.

II. General points to remember

a. The candidate should possess good physical and mental health.

b. Hearing should be good and the candidate should be free from ear, nose and throat disease.

c. The eye vision of candidate should be up to the required medical standards.

d. Speech should be clear and without impediment.

e. The candidate should not have perceptible & visible glandular swelling anywhere in the body.

f. Chest should be well formed, devoid of any abnormality.

g. Limbs should be well formed without any defect and deformities, fully developed and there shall be perfect motion of all the joints.

h. The candidates should not bear traces of previous acute or chronic disease pointing to an impaired constitution.

i. The candidate should possess sufficient number of sound natural teeth for efficient mastication.

j. The candidate should have no obvious disease of genito urinary tract.

k. The candidate should have no inguinal, scrotal swelling.

III. General grounds for rejection and minor acceptable defects

a. Indication of any chronic disease like tuberculosis, syphilis, or other venereal disease, rheumatoid/any type of arthritis, hypertension etc.

b. Bronchial or laryngeal disease like Asthma, chronic Tonsillitis and Adenoids etc.

c. Indication of valvular or any heart disease.

d. Generally impaired constitution, so as to impede efficient discharge of training/duties.

e. Low standard vision.

f. Any degree of squint.

g. Otitis media (an infection of air-filled space behind ear drum)

h. Deafness, any degree of impaired hearing.

i. Stammering.

j. Loss or decay of teeth resulting in reduction of dental points below 14 and wearing of half or complete artificial denture.

k. Contraction or deformity of chest and deformity of joints.

l. Abnormal curvature of spine (exact nature, Ex- Kyphosis, Scoliosis, Lordosis etc to be specified)
m. Abnormal gait.
n. Endocrinal disorders.
o. Mental or nervous instability- evidence of nervous instability.
p. Defective intelligence.
q. Any type of hernia.
r. Chronic skin disease like Vitiligo, Leprosy, SLE, Eczema, Chronic extensive fungal dermatitis.
s. Anal fistula, hemorrhoids and other ano-rectal diseases.
t. Deformities like Flat foot, Club foot, Plantar warts etc.
u. Any congenital abnormality, so as to impede efficient discharge of duties.
v. Epilepsy (history or evidence; history as per Annexure-II).
w. Nystagmus/ Progressive Pterygium.
x. Large hydrocele, even if curable by operation. Small hydrocele (if operated upon and no bad scar is left after operation, may be accepted).
y. Cubitus Varus/Valgus.
z. Polydactyly of hands/feet.
aa. Undescended testis, atrophic testis, marked varicocele, testicular swellings.
bb. The diagnosis of varicose vein should be made on the basis of dilation and tortuosity of veins and after confirmation of incompetency of Saphenofemoral junction/ Sapheno-popliteal junction or perforators by relevant clinical tests. Only prominence of veins should not be criteria for rejection. Cases of Varicose Veins, even if operated, are not to be accepted because basic defect remains unchanged.

NOTE: In case of rejection Medical Examiner shall justify in writing the cause of rejection in recruitment form explicitly.

Acceptance of candidates suffering from trifling defects: Candidates with mild degree of the following defects may be accepted:

a. Mild Flat feet- If the joints of tarsus are flexible and the arch reappears on standing on tip toes.
b. Mild Knock knees- With inter-malleoli distance 5 cm or less.
c. Mild Bow legs-With inter-condylar distance 7 cm or less.
d. Mild Hammer toes- If there are no painful corns or bursae on the dorsum of the toes.
e. Mild Varicocele- If veins are palpable after Valsalva Maneuver, otherwise invisible.
f. Slight stammering- If stammering appears after 4-5 sentences.

g. Healed tympanic membrane perforation.
h. Presence of wax in ears without hearing defect.
i. Mild and moderate DNS (Deviated Nasal Septum) with both nasal airways patent may not be rejected.
j. Bilateral Hypertrophy of inferior turbinate with patent airway.
k. Only prominence of veins in the lower limbs to be accepted.
l. Loss of any soft tissue of terminal phalanx of little finger of one or both hands is to be accepted.
m. Candidates with carrying angle up to 20° may be accepted if the same is not associated with abnormality of elbow joint.
n. Only because of tilting of pelvis or drooping of shoulder may not be rejected unless it is associated with some specific disease/disability.
o. Cervical rib without any functional disability.
p. Only tremors without any organic cause.
q. Healed trachoma without residual gross deformity and no impaired vision.
r. Report of the radiologist must have clinical co-relation before rejection.
s. Any other slight defects which in the opinion of the Medical Examiner will not interfere with efficiency of candidate in performance of his/her duties.

The following points may further be taken into consideration:

a. In all cases where a candidate suffering from trifling defects is accepted, the medical examiner should fully satisfy himself that the defect will not in any way affect the efficiency of candidate and the defects should invariably be mentioned in recruitment form.
b. Candidates suffering from minor defects of ordinary nature such as simple sores, shoe bite, common cold and similar other minor ailments which usually last only a few days, may be accepted. The Medical Examiner before accepting such a candidate must fully satisfy himself that the disease is likely to be cured in a few days with outdoor treatment.
c. In doubtful cases candidates may be referred to a specialist for examination and opinion which may include X-ray examination or any other specialised investigation/test/examination.

IV. General instructions for the examination of female candidates

a. Female candidates should be examined by female medical examiner only. However, if 2 or more doctors are there in the medical board; lady medical officer will also be a member, in whose presence medical examination will be carried out for female candidates.
b. Female candidates should be properly examined for any lump or diseases of breast and Genitourinary system after taking proper

consent. In case any disease/condition is diagnosed which would interfere in the performance of duties she is recruited for, the candidate will be declared unfit.

c. Chest measurement of female candidates should not be taken. However, it should be ascertained that the chest is well developed.
d. In females, the carrying angle of more than 20° will lead to rejection on the ground of cubitus valgus.
e. Genitalia

(Note- per-speculum and per-vaginal examination are not to be performed in an unmarried candidate; however, inspection of genitalia is to be done to rule out any obvious pathology).

i. Evidence of major abnormalities or defects of the genitalia such as change of sex, hermaphroditism, pseudo hermaphroditism, or gonadal dysgenesis or dysfunctional residuals even after surgical correction of these conditions is disqualifying.
ii. If candidate reports with bleeding P/V, she may be called after 5 days or after cessation of menstruation, whichever is earlier, provided the candidate is not willing for genital examination at the time of medical examination.
iii. If urine test for pregnancy is positive the candidate will be declared temporarily unfit and will be re-examined 6 weeks after the pregnancy is over, either naturally or artificially, subject to the production of a medical certificate of fitness from a registered medical practitioner.
iv. Genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, is disqualifying.
v. Any operated case (Open/Laparoscopic) of ovarian cyst, fibroid, ectopic pregnancy, caesarean section etc are to be rejected until 06 months have elapsed after surgery, provide that operative scar mark is well healed and there is no evidence of incisional hernia.
vi. Evidence of ovarian cyst or fibroid uterus or any other lump is disqualifying.
vii. Evidence of pelvic inflammatory disease, is disqualifying.
viii. Congenital absence of uterus, or enlargement due to any cause is disqualifying.

V. Direction for general examination

The medical examiner can examine the candidates in any sequence as he desires. However, a stepwise sequence of examination as given is advised to be followed by all medical examiners so that any disease/disability is not overlooked. Physical examination of candidate is carried out from head to toe.

Steps of Medical Examination:

Identity of the candidates should be properly established by all means. Identification marks should be noted concisely and clearly, giving importance to the visible marks and preferably at the different parts of the body.

Step-I

Firstly, examine the following body parts:

a. Eyes and vision
b. Ears and hearing
c. Nose, sinuses and larynx
d. Oral cavity
e. Dental conditions

Step-II

a. The points to be observed and noted in part of the examination are the following:
    i. General physical development.
    ii. Formation and development of limbs.
    iii. Power and Range of Movement in joints including gait.
    iv. Flatness of feet.
    v. Any abnormality of toes.
    vi. Skin disease
    vii. Cicatrized marks or keloids not causing functional disability.
b. Now look for any obvious abnormality, as though scanning whole of the body.

    Standing- General Survey
    i. Head
    ii. Neck
    iii. Chest wall
    iv. Abdomen wall
    v. Upper limbs
    vi. Lower limbs
    vii. Miscellaneous conditions of the extremities.
    viii. Skin
    ix. Spine and sacroiliac joints.
    x. General and miscellaneous conditions and defects.
    xi. Genitalia including inguinal regions.
    xii. Ano-rectal region.
c. Sitting
    i. CVS
    ii. Respiratory system
d. Lying
    i. Abdominal organs and gastrointestinal system.

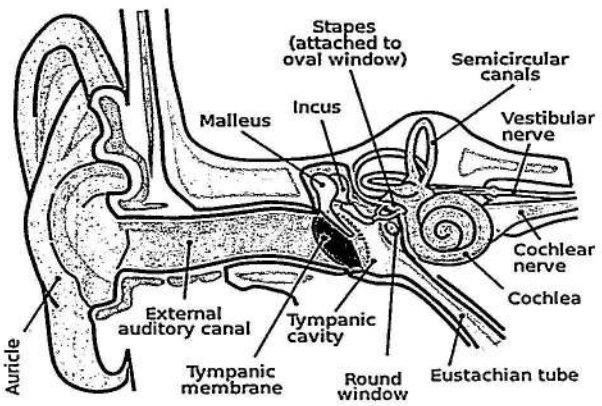
ii. Tests for joints integrity of lower limbs for ligamentous injuries.
iii. Tests for varicose veins.

e. Body weight (Height-Weight matrix): Medical examiner need not record the physical measurements. He will mention physical standard in the medical examination form as recorded by the PE&MT board. In borderline cases of overweight, BMI should also be considered to arrive at conclusion and variation of 5Kg +/- from the minimum/maximum limit may be accepted. Standard height-weight chart is attached at Annexure-I.
f. The candidate is required to fill up a self-declaration form duly signed by him/her as per Annexure II.

3. DETAILED MEDICAL EXAMINATION (DME form at Annexure III)

I. Examination of ears and hearing standards

a. Deafness- Deafness of any degree should be unfit.
b. Persistent ear discharge- Candidate should be declared unfit.
c. Perforation of Tympanic Membrane-healed perforation without any hearing defect should be accepted.
d. Any other condition (congenital or acquired) like Atresia of the meatus, exostosis, neoplasm which is causing obstructions of ear passage and history of recurrent earache, tinnitus and vertigo should be rejected.



1. Hearing Tests: Normally a candidate should be able to hear forced whisper at distance of 06 metres behind his back with each ear separately. It should be carried out preferably in a quiet room individually with the help of an assistant. Candidate is asked to stand near a wall facing him/her. The examiner will stand at a distance of 06 meters. The test will be done for each ear separately after plugging of the other ear. Simple and effective way is to ask an assistant to rub a piece of paper gently and continuously with a pencil or finger on the ear not under test. The force whisper is made with

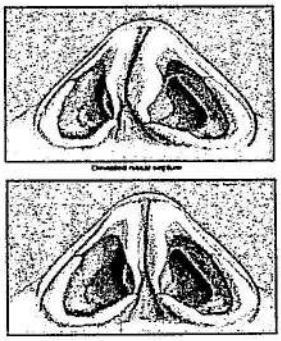
the residual air at the end of normal expiration. If the candidate can hear with both the ears separately, then his hearing is normal. If he/she is unable to hear this, the distance will be reduced till he is able to hear. Thus, if the distance is less than 06 meters, the candidate is rejected.

2. Candidate should be declared unfit having following diseases:
    a. External ear: Atresia or severe microtia, congenital or acquired stenosis, or any other severe external ear deformity.
    b. Mastoids: Mastoiditis as well as its complications like residual mastoiditis with fistula, chronic drainage or conditions requiring frequent cleaning of the mastoid bone.
    c. Middle and inner ears: Chronic otitis media, cholesteatoma, or history of any inner or middle ear surgery (including cochlear implantation).
    d. Tympanic membrane: Existing perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 4 months.

II. Examination of nose, sinuses and larynx

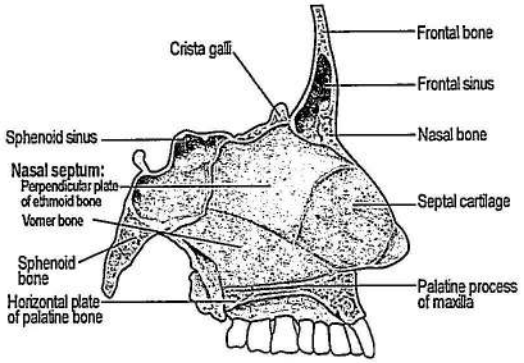
Nose should be carefully examined and ensured that airways are free. Complete examination of nose with the help of nasal speculum is to be done to rule out polyps of nose, Deviated Nasal Septum or Atrophic Rhinitis. To test the nasal obstruction the candidate is asked to exhale forcefully through one nostril while other is kept closed with the tip of thumb. Same procedure is repeated for the other nostril. Right thumb may be used for right nostril and left thumb for the left nostril.

a. DNS, atrophic rhinitis, tubercular ulceration, chronic sinusitis are required to be excluded; however minor DNS, minor hypertrophied turbinate can be accepted if there is no marked airway obstructions.
b. Candidates with polyps should be declared unfit and if after 1 month of surgery there is no complication, these candidates can be accepted during review medical examination.
c. The candidates should also be declared unfit if having any of the following diseases:
    i. Atrophic rhinitis
    ii. Nasal polyps
    iii. Perforation of nasal septum
    iv. Marked DNS with nasal airway obstructions.
    v. Deformities, or conditions or anomalies of the upper alimentary tract, viz., mouth, tongue, palate, throat, pharynx, larynx, mandible and nose that interfere with chewing, swallowing, speech, or breathing.



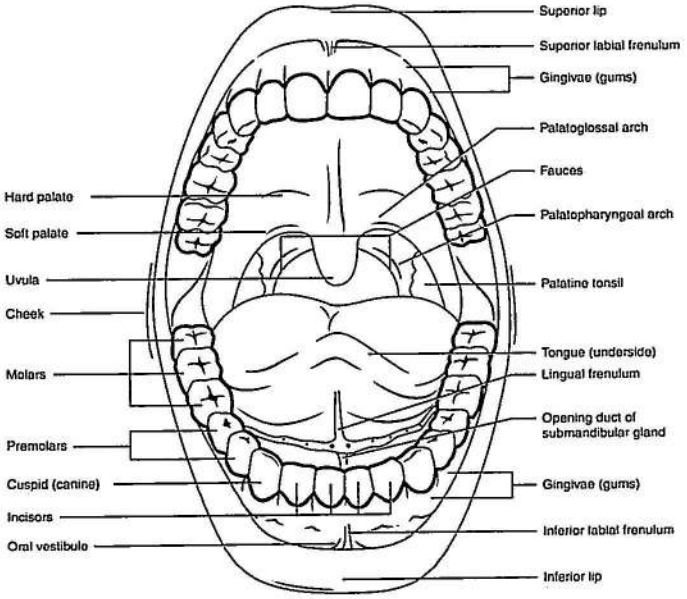
Deviated Nasal Septum

Nasal Polyp



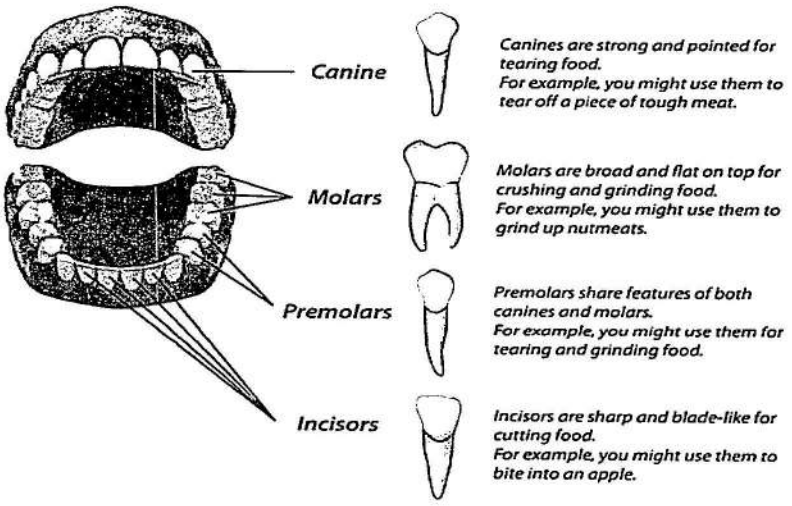
Sagittal section

III. Dental examination



1. General Considerations:
    a. The acceptance or rejection of a candidate on account of loss or decay of teeth will depend on the relative positions of the sound teeth.
    b. A candidate must have sufficient number of natural teeth to enable him to masticate efficiently and on no account will be accepted, if he/she requires artificial dentures for efficient mastication (i.e. artificial fixed denture replacing any molar).
    c. In order to assess whether a candidate has a sufficient number of teeth to masticate efficiently, the following guidelines will be taken into consideration for calculation of Dental points.

2. Calculation of Dental Points:



    a. Teeth which are not considered necessary for efficient mastication are allotted ONE POINT each and those essential TWO POINTS each.
    b. Each Incisor, Canine, 1st and 2nd Premolar will have one point provided that corresponding lower teeth are present.
    c. Each 1st and 2nd Molar and well-developed 3rd Molar will have the value of two points provided in good apposition to corresponding teeth in the lower jaw.
    d. In case of 3rd molar not well developed it will have a value of one point only.
    e. When all the 16 teeth are present in the upper Jaw and in good functional apposition to corresponding teeth in the lower jaw, the total value will be 20 or 22 points according to whether the 3rd molar are well developed or not.

f. The following natural teeth will be present in the upper jaw in good functional apposition to the corresponding teeth in the lower jaw:
   i. Any 4 of the 6 anterior
   ii. Any 6 of the 10 posteriors

Thus, the dental points will be counted as under:

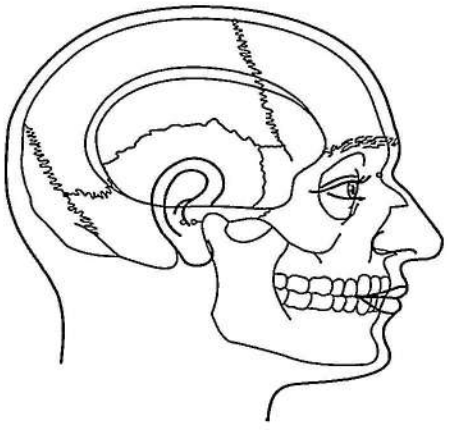
S.No.	Name to teeth	Teeth in either jaw	Number allotted for each tooth, if in good functional apposition to the corresponding teeth in the other jaw	Dental points
1	Incisors	4	1	4
2	Canine	2	1	2
3	Premolars	4	1	4
4	Molars	6	2	12

Maximum total points = 4+2+4+12=22

A candidate will be accepted provided there are at least 14 Dental points in his/her mouth and all these teeth must be sound or repairable. Thus, the minimum number of points required in a candidate will be 14. Well filled teeth will be considered as sound. No points will be counted for artificial denture.

3. Examination of Gums:
   Pyorrhea: Normal gums are pink and adhere closely to the teeth and have a sharp border. Candidates having severe pyorrhea in which the gums are retracted, may bleed easily and sometimes pus can be squeezed from them, should be rejected. If pyorrhea is slight and teeth are otherwise sound, the candidate may be accepted.

IV. Examination of head



Candidate should be declared unfit having following diseases:

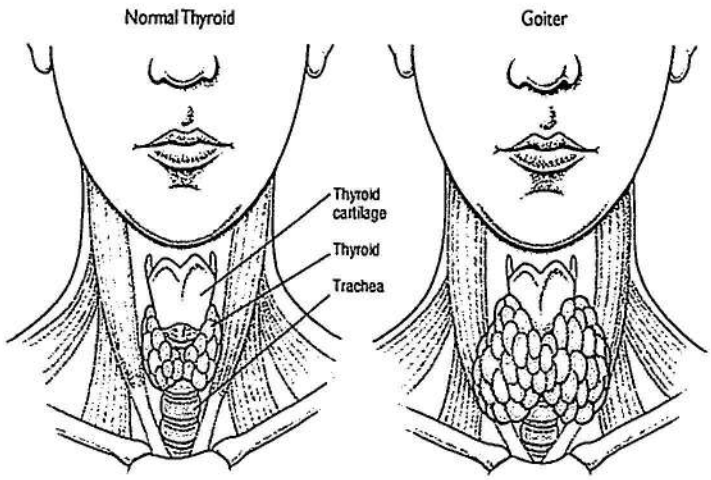
1. Uncorrected deformities of the skull, face, or mandible of a degree that would prevent the individual from wearing a protective mask or combatised headgear.
2. Loss or absence of the bony substance of the skull, not successfully corrected by reconstructive materials and leaving residual defect.
3. Head Injury
    a. Severe head injury: History of head injury will be disqualifying if associated with any of the following:
        i. Post-traumatic seizures occurring more than 30 minutes after injury.
        ii. Persistent motor or sensory deficits.
        iii. Impairment of intellectual function.
        iv. Alteration of personality.
        v. Unconsciousness, amnesia, or disorientation of person, place or time of 24-hours duration or longer post-injury.
        vi. Multiple fractures involving skull or face.
        vii. Cerebral laceration or contusion.
        viii. History of epidural, subdural, subarachnoid, or inter-cerebral hematoma.
        ix. Associated abscess or meningitis.
        x. Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.
        xi. Focal neurologic signs.
        xii. Radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.
    b. History of moderate head injury is disqualifying after 2 years post-injury. Applicants may be qualified if neurological consultation shows no residual dysfunction or complications. Moderate head injuries are defined as unconsciousness, amnesia, or disorientation of person, place, or time, alone or in combination, of more than 1 and less than 24-hours duration post-injury, or linear skull fracture.
    c. History of mild head injury is disqualifying after one-month post-injury. Applicants may be qualified if neurological evaluation shows no residual dysfunction or complications. Mild head injuries are defined as a period of unconsciousness, amnesia, or disorientation of persons, place, or time, alone or in combination of 1 hour or less post injury.
    d. History of persistent post-traumatic symptoms that interfere with normal activities or have duration of greater than 1 month is disqualifying. Such symptoms include, but are not limited to headache, vomiting, disorientation, spatial disequilibrium,

impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

V. Examination of neck

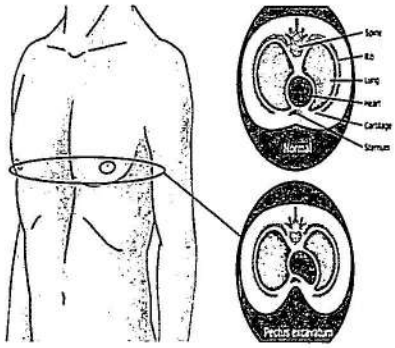
Candidate should also be declared unfit if having any of the following diseases:

a. Symptomatic cervical ribs.
b. Congenital cysts of branchial cleft origin or those developing from remnants of the thyroglossal duct, with or without fistulous tracts.
c. Contraction of the muscles of the neck spastic or non-spastic, or cicatricial contracture of the neck, to the extent that it interferes with the proper wearing of a uniform or equipment or is so disfiguring as to interfere with or prevent satisfactory performance of Police duty.
d. Goitre
e. Cervical lymphadenopathy
f. Any spinal deformity including restricted movements.
g. Any cystic swelling or sinuses.

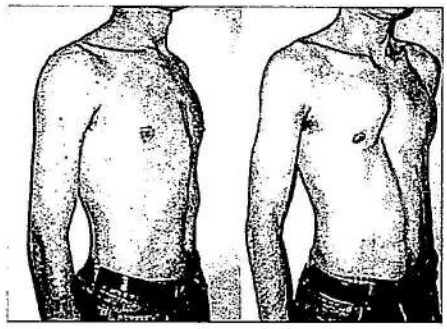


VI. Examination of chest wall

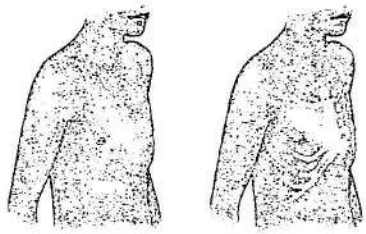
Examination is done with candidate standing with his/her arms extended above his/her head, the hands being in contact. Chest wall is looked for deformities/malformations, including but not limited to Pectus Excavatum, Pectus Carinatum, Pectus Arcanum, Poland Syndrome etc.



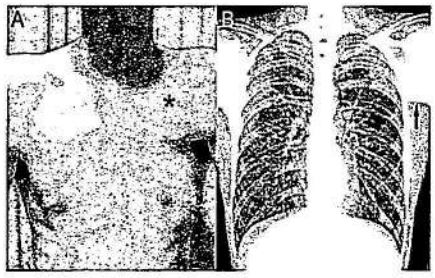
Pectus excavatum



Pectus carinatum



POLAND SYNDROME
Under Developed left chest wall



Absent right Pectoris Major Muscle

VII. Examination of upper extremities

1. General Consideration

   The upper extremities will be examined from fingers to shoulder joints. Time is saved by the medical examiner himself demonstrating as well as instructing the candidate to carry out the movements as desired to be made. The following are the directions to be given to the candidate to know the muscle power, range of movement etc. – Stretch out your arms with the palms of both hands upwards.

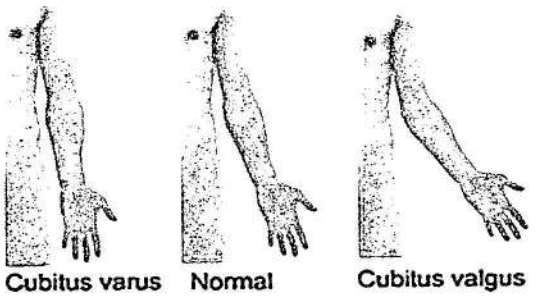
   a. Bend your thumbs across the palms of your hands.
   b. Bend the fingers over thumb.
   c. Bend your wrist backwards & forwards.
   d. Bend the elbows.
   e. Turn the back of the hands upwards.
   f. Swing your arms around your head.

   Specific note is made for any following conditions:

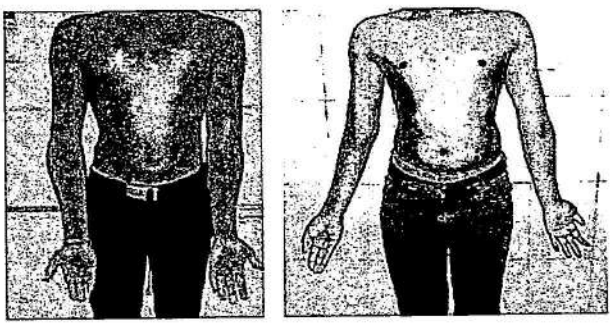
   a. Operative scar mark.
   b. Tremors
   c. Contractures
   d. Muscle wasting
   e. Any limitation of joint movements.
   f. Bony deformities elbow.
      i. Fixed flexion deformities.

ii. Cubitus Valgus/Varus

2. Carrying angle
   a. Normal angle: The carrying angle of the elbow is defined as the angle between the long axis of the extended forearm as it lies lateral to the long axis of the arm. Thus, this angle is the normal outward deviation of the extended and supinated forearm from the axis of the arm. This angle is normally 10°-15° in males, and in female 15°-20°. However, candidates with carrying angle up to 20° may be accepted if the same is not associated with abnormality of elbow joint.
   b. Cubitus Valgus: The carrying angle apparently develops in response to pronation of the forearm and keeps the swinging upper extremity away from the side of the pelvis during walking. Increasing the carrying angle may lead to elbow instability and pain during exercise or in throwing activities of sports, may reduce function of elbow flexion, predisposing to risk of elbow dislocation and increase evidence of elbow fracture when falling on outstretched hand and fracture of the distal humeral epiphysis.



   c. Cubitus varus:



If the angle is decreased so that the extended forearm is deviated towards midline of the body, it is called cubitus varus. It is often

referred to as 'Gunstock deformity', due to crooked nature of the healing. Cubitus Varus is a cause for rejection.

3. Hand and fingers:
   a. Loss of only soft tissue of terminal phalanx of little finger of one or both hands is to be accepted.
   b. Polydactyly/syndactyly is disqualifying.
   c. Scars and deformities of the fingers or hand that impair normal functioning/free movement of the fingers/hand to such a degree as to interfere with the satisfactory performance of duties, are disqualifying.
   d. Presence of paralysis or weakness of upper limbs, including nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar and radial nerve, sufficient to produce physical findings in the hand, such as muscle atrophy and weakness is disqualifying.
   e. Presence of disease, injury, or congenital condition with residual weakness or symptoms such as to prevent satisfactory performance of duty, including, but not limited to chronic joint pain, shoulder, upper arm, forearm, and hand, late effect of fracture of the upper extremities, late effect of sprains without mention of injury and late effects of tendon injury are disqualifying.

VIII. Examination of abdominal wall

Whole of the abdomen wall is inspected for any operative scar mark or any swelling including hernia (epigastric, umbilical or incisional etc.) and appropriate decision should be taken.

1. Presence of any hernia is disqualifying. However, the cases of well repaired/ operated by open/laparoscopic surgery with well-healed scar without any recurrence and having completed the duration of more than six months after surgery at the time of medical examination are acceptable.
2. Cases of operative scar mark anywhere at abdominal wall are to be investigated with appropriate and relevant investigation like ultrasound/CT scan abdomen to rule out any underlying pathology/loss of any intra-abdominal organ and opinion of the surgical specialist of a government hospital before arriving at final decision.
3. Artificial openings including, but not limited to ostomy, are disqualifying.

IX. Examination of lower extremities

1. General Considerations:
   a. Both the lower limbs must be inspected, preferably from toes to upwards. The following shall be looked for:

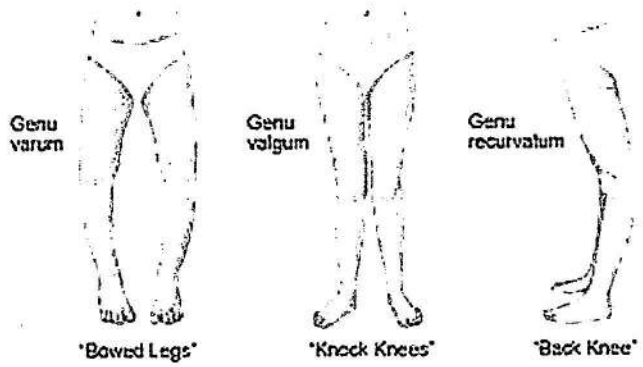
i. Knock-knee
ii. Bow leg
iii. Flat foot
iv. Deformities of feet including brachymetatarsia.
v. Mal-developed or absent toes.
vi. Bony deformities
vii. Varicose vein
viii. Varicose ulcer
ix. Sinuses
x. Muscle wasting

b. The following are the directions to be given to the candidate to know the muscle power, range of movement etc.
   i. Stand on your right foot, pull the left foot upwards.
   ii. Bend the ankle joints & toes alternatively backwards & forwards.
   iii. Repeat with other foot.
   iv. Up again
   v. Kneel down on one knee.
   vi. Up again
   vii. Down on both knees & up from position with simultaneous spring on both legs.

   The examination of lower extremities should preferably be done outdoor.

2. Deformities and their assessment:
   a. Knock Knee: A separation of internal malleoli of over 5 cm will be a disqualification. In case of female candidates, the maximum permissible inter-malleolar distance is 08 cm.

Inspection: Standing

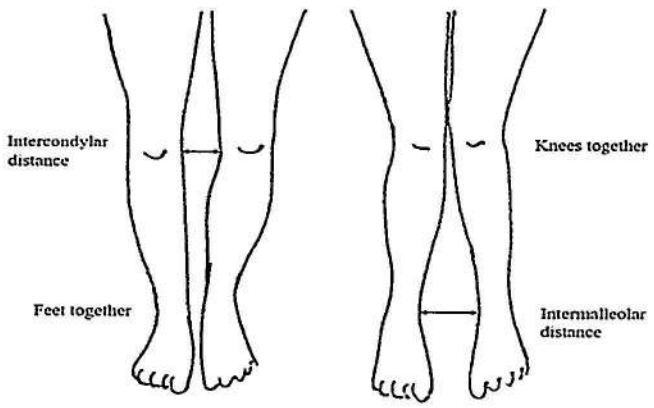


PROCEDURE

The candidate is made to stand with the internal malleoli approximated and look for any over-riding of both the knees. To confirm, the

candidate is asked to lie down on examination table with patellae facing towards ceiling, vertically up and straight. One of the lower limbs is lifted up to approximate with the medical condyle of opposite side. The distance between the internal malleoli is then measured with the help of a 05 cm long wooden block. The reading more than 05 cm is a cause of rejection as knock knee.

The same test can be done with the body sitting upright on a chair, the legs fully extended in front & knees just touching (passively, with the help of the assistant).

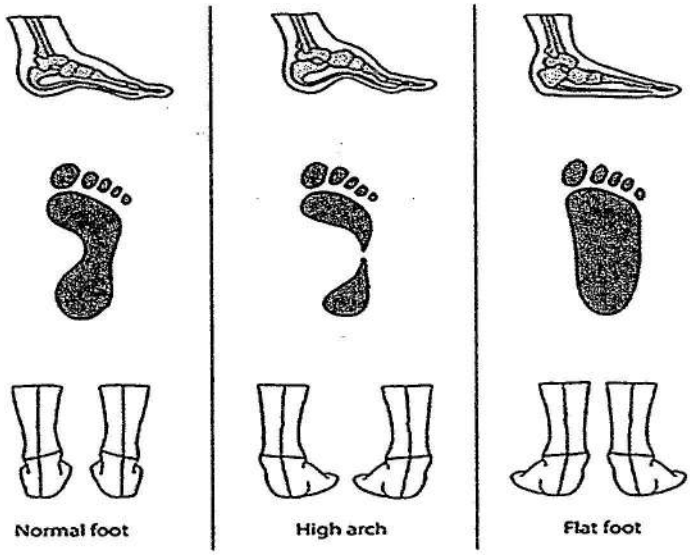


b. Bow Legs: The candidate is asked to stand with the Internal malleoli approximated and the distance between both the medial condyles is noted. To confirm, the candidate is asked to lie down on examination with patellae facing towards ceiling and both the medial malleoli are in approximation. Now, the distance between both the medial condyles is measured with a piece of wooden block, measuring 07 cm. A reading more than 7 cm is a cause of rejection as bow legs.

c. Flat Feet: The candidate is made to stand with his back towards the Medical Examiner. He is then asked to bend one leg from the knee and hold the foot just above the ankle with his corresponding hand. This would enable the Medical Examiner to examine the sole of the foot. Subsequently the other foot is also examined. During the examination of the sole, the shape of the foot including the formation of the longitudinal and transverse arches is noted. The candidate may be asked to fully wet his both feet and walk on the dry floor so as to leave his foot prints. The foot print is to be checked whether it is with or without any arch formation.

However, the following also be observed while declaring a candidate unfit due to Flat Feet:

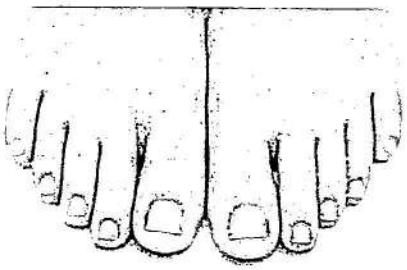
i. Prominent tuberosity of navicular bone
ii. Flattening of the arch
iii. Valgus heel
iv. Faulty shoe wear



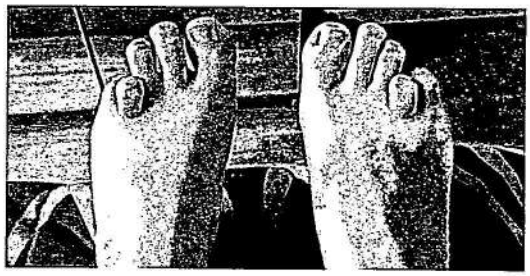
If the joints of tarsus are flexible & the arch reappears on standing on tip toe, the same shall be accepted. The re-appearance of arch must also be checked by asking the candidate to dorsi-flex his great toe with his hand while sitting on a stool and keeping the testing leg over the other thigh. If the feet everted, tarsal joints are stiff or tender points are detected, the same shall be disqualifying.

d. Hammer Toes: It is a fixed flexion deformity of an inter-phalangeal joint of the toe. The candidate with hammer toes should be rejected, if there are painful corns or bursae on the dorsum of toes.

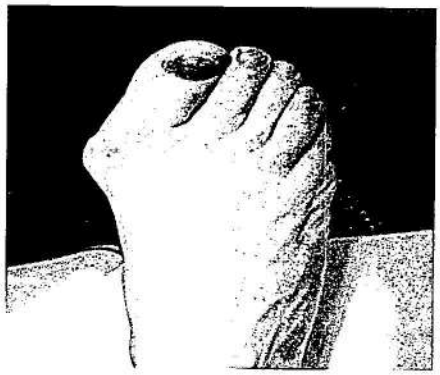
e. Hallux Valgus: It is the outer deviation of the great toe at the metatarsophalangeal joint. Usually, it is a bilateral condition. Candidates are to be disqualified, if one or all following features are present.
   i. The proximal Phalanx of the Great Toe in addition to being valgus is rotated so that its plantar aspect is visible.
   ii. There is a callosity on the inner aspect of the great toe.



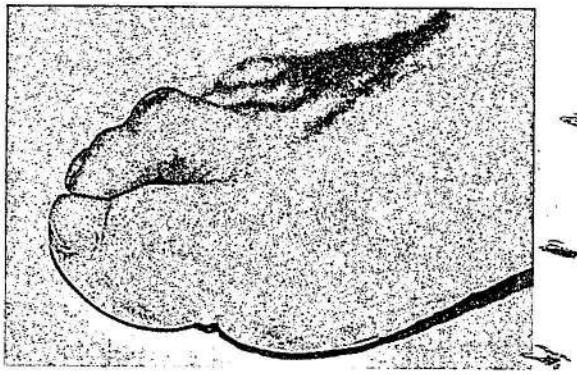
Normal Toes



Brachymetatarsia



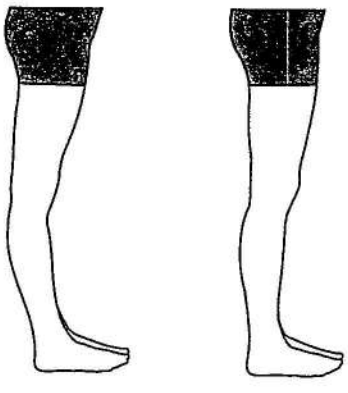
Hallux Valgus



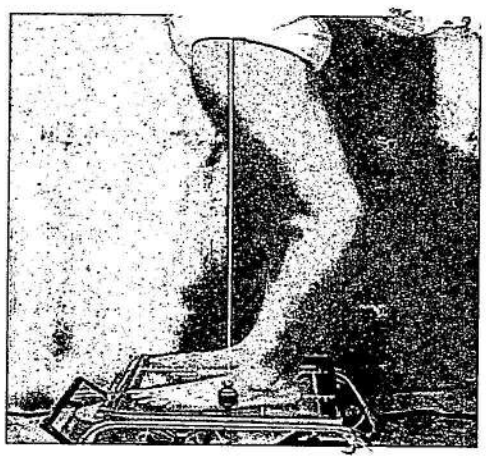
Hammer Toes

f. Hallux Rigidus: It is the condition in which there is no movement at metatarsophalangeal joint of great toe, and these candidates are to be rejected.

g. Genu Recurvatum: It is a congenital condition in which the knee joint is hyper extended, and such candidates are to be rejected. However, only in cases where hyperextension goes beyond 10° should a diagnosis of genu recurvatum be made.



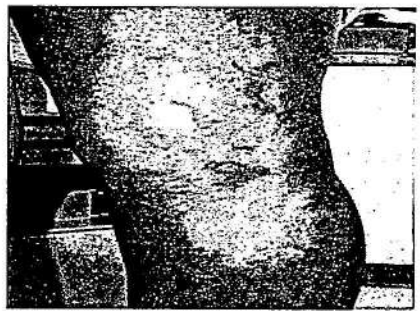
Genu Recurvatum **Neutral**



Measurement of G. Recurvatum

h. The following will also be looked for:
    i. Any limitation of joint motion: The limitation of joint motion is disqualifying.
    ii. Foot and Ankle
        a) Absence of a foot or any portion thereof is disqualifying.
        b) Presence of deformities of the toes (acquired or congenital, including, but not limited to conditions such as hallux valgus, hallux varus, hallux rigidus, claw toes, overriding toes, (that prevents the proper wearing of footwear or impairs walking, marching, running, or jumping) are disqualifying.
        c) Clubfoot (talipes) or high-arched foot (pes cavus) that prevents the proper wearing of footwear or impairs walking, marching, running, or jumping is disqualifying.
        d) Presence of flat foot (pes planus) as mentioned before.
        e) Presence of ingrown toe nails, if infected, is disqualifying.
    iii. Leg, Knee, Thigh and Hip
        Following candidates are to be disqualified:
        a) Evidence of uncorrected anterior or posterior cruciate ligament injury.
        b) Evidence of surgical correction of knee ligaments.
        c) Evidence of medial and lateral collateral ligament injury.
        d) Evidence of symptomatic medial and lateral meniscal injury.
        e) Evidence of unspecified internal derangement of the knee.
        f) Evidence of hip dislocation is disqualifying.
    iv. General
        a) Presence of deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, ankle and/or foot that interfere with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or duty, are disqualifying.
        b) Presence of leg-length discrepancy resulting in a limp is disqualifying.
i. Varicose veins: According to WHO, Varicose veins are abnormally dilated saccular or cylindrical superficial veins, which can be circumscribed or segmental.

Spider Veins



Reticular Veins

i. Classification: International Consensus Committee on chronic venous disease (Porter) 1995
   a. Varicose veins: Dilated, palpable, subcutaneous veins usually >04 mm in diameter.
   b. Reticular veins: Dilated, non-palpable, sub-dermal vein usually <04 mm
   c. Telangiectasia: Dilated, intra-dermal venules usually <01 mm.

ii. Apparent straight veins:
   a. Extremely prominent superficial veins, found in young muscular individual.
   b. Unlike trunk varicose veins, they are usually uniformly dilated and exhibit no tortuosity or elongation.
   c. These veins are physiological, not pathological.

(The candidate will be disqualified on the grounds of having varicose veins only, as mentioned at serial no. (i)(a) above.)

j. Miscellaneous condition of the extremities:
   i. Presence or history of chondromalacia (an affliction of cartilage coating of the bone), including, but not limited to chronic-patella-femoral pain syndrome and retro-patellar pain syndrome, chronic osteoarthritis or traumatic arthritis is disqualifying.
   ii. Presence of joint dislocation if unreduced or history of recurrent dislocation of any major joint such as shoulder, hip, elbow, knee, ankle, or instability of any major joint (shoulder, elbow, hip, ankle and foot or multiple sites) is disqualifying.
   iii. History of recurrent instability of the knee or shoulder is disqualifying.
   iv. Presence or history of chronic osteoarthritis or traumatic arthritis of isolated joints of more than a minimal degree that has interfered with the following of a physically active

vocation, or that prevents the satisfactory performance of duty is disqualifying.

v. Presence or history of any fracture associated with mal-union or non-union is disqualifying. However, a well healed and consolidated fracture on X-ray without any in-situ implant, non-union, mal-union, joint involvement and any consequent loss of mobility & functional disability resulting from fracture or its management, may be accepted.

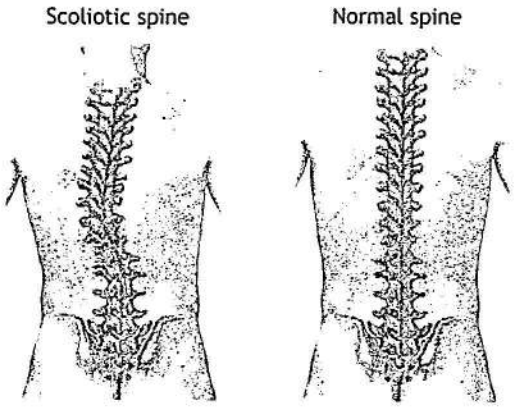
vi. History of joint replacement of any site is disqualifying.

vii. Presence or history of muscular paralysis, contracture, or atrophy, if progressive or of sufficient degree to interfere with or prevent satisfactory performance of combatised duty or if it will require frequent or prolonged treatment is disqualifying.

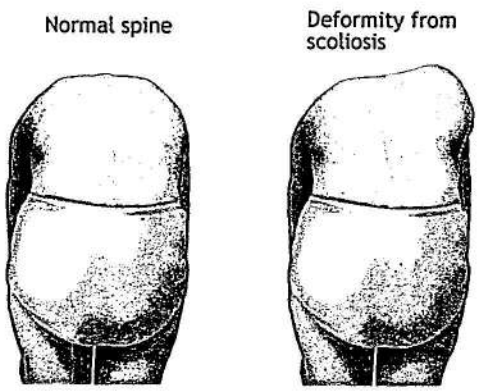
viii. Presence of osteomyelitis or history of recurrent osteomyelitis is disqualifying.

X. Examination of spine and sacroiliac joints

1. Presence or history of ankylosing spondylitis or other inflammatory spondylopathies is disqualifying.
2. Presence or history of any condition, including, but not limited to the spine or sacroiliac joints, with or without objective signs that:
    a. prevents the individual from successfully following a physically active vocation or that is associated with local or referred pain to the extremities, muscular spasm, postural deformities, or limitation of motion is disqualifying.
    b. requires external support is disqualifying.
    c. requires limitation of physical activity or frequent treatment.
3. Presence of deviation or curvature of spine from normal alignment, structure, or function is disqualifying. For scoliosis, the following signs should be looked for:
    a. One shoulder is higher than the other.
    b. One shoulder blade sticks out more than the other.
    c. One side of the rib cage appears higher than the other.
    d. One hip appears higher or more prominent than the other.
    e. The waist appears uneven.
    f. The body tilts to one side.
    g. One leg may appear shorter than the other.



(One of the most common tests for detecting scoliosis is called the Adam's Forward Bend Test, in which the individual bends from the waist as if touching the toes.)



4. History of congenital fusion, involving more than two vertebral bodies is disqualifying.
5. Any surgical fusion of spinal vertebrae is disqualifying.
6. Presence or history of fractures or dislocation of the vertebrae is disqualifying.
7. Presence of herniated nucleus pulposus or history of surgery to correct this condition is disqualifying.
8. Presence or history of spina bifida, if there is more than one vertebra level involved or with dimpling of the overlying skin, is disqualifying.
9. History of surgical repair of spina bifida is disqualifying.
10. Presence or history of spondylolysis (congenital or acquired) and spondylolisthesis (congenital or acquired) are disqualifying.

XI. Examination for skin diseases and leprosy

1. Leprosy: Examination for any hypo-pigmented area which is usually anesthetic, thickened and enlarged peripheral nerves especially ulnar nerve over ulnar groove, ulceration on mucous membranes of the nose

or mouth etc. must be done carefully, if ulnar nerve is found palpable and thickened then the superficial auricular nerve and posterior tibial nerve should also be palpated. All such cases are to be rejected.

2. Other conditions which are to be considered for rejection:
    a. Severe acne, if extensive involvement of the neck, shoulders, chest, or back is present or would be aggravated by or interfere with the proper wearing of combatised equipment are disqualifying.
    b. Atopic dermatitis or infected extensive eczema.
    c. Contact dermatitis especially involving materials which are used in any type of required protective equipment is disqualifying.

    d. Cysts:
        i. Cysts (other than pilonidal cysts) of such a size or location as to interfere with the proper wearing of combatised equipment is disqualifying.
        ii. Pilonidal cysts, if evidenced by the presence of a tumor mass or a discharging sinus is disqualifying. Surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative is disqualifying.
    e. Bullous dermatoses, including, but not limited to dermatitis herpetiformis, pemphigus, and epidermodysplasia, is disqualifying.
    f. Chronic lymphedema is disqualifying.
    g. Localized types of fungus infections, which is extensive, interfering with the proper wearing of combatised equipment or the performance of combatised duties, are disqualifying.
    h. Congenital or acquired anomalies of the skin such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation are disqualifying. History of Dysplastic Nevus Syndrome is disqualifying.
    i. Keloid formation, if the tendency is marked or interferes with the proper wearing of combatised equipment, is disqualifying.
    j. Lichen planus is disqualifying.
    k. Neurofibromatosis (von Recklinghausen's disease) is disqualifying.
    l. Psoriasis is disqualifying.
    m. Scars, or any other chronic skin disorder or a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority affect thermoregulatory function, or will interfere with the wearing of combatised clothing or equipment, or which exhibits a tendency to ulcerate, or interferes with the satisfactory performance of

duty, are disqualifying, includes scars at skin graft donor or recipient sites.

n. Scars at skin graft donor or recipient sites will include an evaluation of not only the relative total size of the burn wound, but also the measurable effects of the wound, the location of the wound and the risk is subsequent injury related to the wound itself.

o. Prior burn injury (to include donor sites) involving a total body surface area of 40 per cent or more is disqualifying.

p. Prior burn injury involving less than 40 per cent total body surface area, which results in a loss or degradation of thermoregulatory function is disqualifying. Examination will focus on the depth of the burn, anatomic location (extensive burns on the torso will most significantly impair heat dissipation) and destruction of sweat glands.

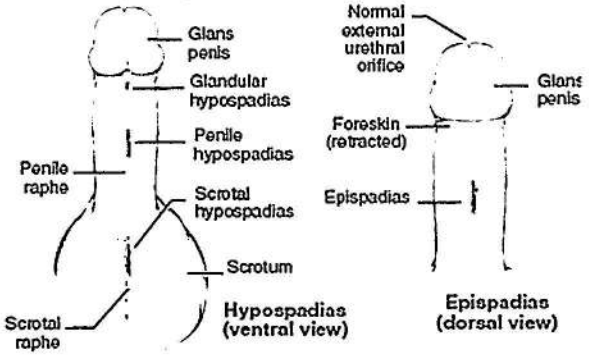
q. Prior burn injury susceptible to trauma or resulting in functional impairment to such a degree as to interfere with the satisfactory performance of combatised duty, due to decreased range of motion, strength, or agility due to burn wound/scarring is disqualifying.

r. Extensive scleroderma (hardening and tightening of skin) is disqualifying.

XII. Examination of inguinal region and genitals

1. This examination should be carried out in well lighted room considering the privacy of individual. The candidate should be examined after removing undergarments.
2. This examination for hernia and varicocele is always done with the candidate in standing posture.
3. The following points should be looked for:
   a. Skin Disease: Like eczema, scabies, boils and fungal infection etc. These diseases are common in scrotal skin and groin and may extend to hips also, are to be disqualified if extensive.
   b. Scar Marks: Old scar marks indicating previous operation for hernia, Hydrocele and Undescended/Ectopic Testis are to be noted and appropriate decision is to be taken based on possibility/tendency of recurrence and functional hinderance caused by it.
   c. Penis: Penis should be examined for any wart, ulcer, discoloration discharge or tumor and these cases are to be rejected. The cases of hypospadias and epispadias or meatal stenosis should also be rejected. The individual is asked to retract the preputial skin and if failed, such cases of phimosis should be rejected.

Hypospadias and Epispadias

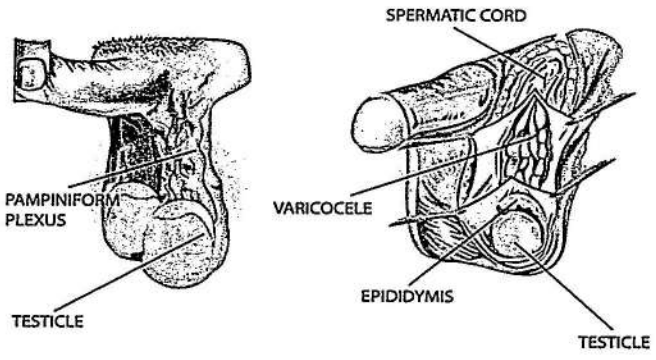


d. Inguinal Region: Inguinal hernia is the possibility at the young age. The candidate should be asked to turn his head away from the examiner and cough. A swelling will appear on coughing. It can also to be confirmed by VALSALVA MANEUVER. Operated cases (with documentary proof) of inguinal hernia may be accepted if the scar is well healed, supple and non-tender; the tone of abdominal muscles is good and there is no tendency for recurrence 6 months after operation. An operated case will not be accepted within 6 months of surgery.

e. Scrotum: Look if both the testis are in the scrotal sac and of normal size. The scrotum should be examined for Hydrocele, Varicocele and abnormality of the testis like undescended testis, ectopic testis, atrophic testis or neoplasia of testis. Grade I Varicocele is acceptable. Undescended testis/ectopic testis and atrophic/ hypotrophic testis are considered as disqualification.
Grading of the Varicocele:
   i. Grade I/Mild- Palpable with Valsalva Maneuver.
   ii. Grade II/Moderate- Palpable at rest (without Valsalva Maneuver) but invisible.
   iii. Grade III/Severe- Easily visible.

(Varicocele:

   i. Mild degree of varicocele on the left side, uncomplicated and symptomless should not be a bar to acceptance. However, mild degree of varicocele on the left side associated with the atrophy will be rejected.
   ii. Moderate to severe degree of varicocele on the left side even without any testicular atrophy will be rejected.
   iii. Right sided varicocele of any degree will be declared unfit.)



f. Perineum and Ano-rectal region:

i. The candidate should be instructed to turn his back, stoop down and separate the buttocks with his hands. One can then examine for anal warts (Condylomata), Fistula-in-ano, Pilonidal sinus, Prolapse Rectum, Fissure and External Piles. The candidate should be asked to strain, as to defecate, so that Fissure-in-ano, Internal and External piles or prolapse of rectum become more evident. The cases of anal warts (Condylomata), Fistula in ano, Prolapse Rectum and hemorrhoids should be rejected. If candidate gives a history of STD or shows clinical signs of old healed STD lesions, he should be rejected.

ii. Sexually Transmitted Disease: Candidates presenting any condition of STD are not eligible for enrolment. They should be carefully examined by Medical Examiner for chancre or ulcer on penis, enlarged regional lymph nodes, condylomata, urethral discharge etc. and these candidates with or without history of exposure are to be rejected.

iii. Ano-rectal

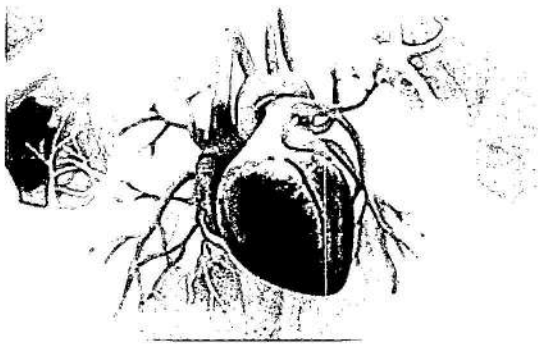
a) Evidence of anal fistula is disqualifying.
b) Evidence of anal or rectal polyp, prolapse, stricture, or fecal incontinence is disqualifying.
c) Hemorrhoid (internal or external) with evidence of bleeding, is disqualifying.
d) Mere presence of anal tag and sentinel pile is not a criterion for rejection.

iv. Male Genitalia

a) Amputation of penis is disqualifying.

b) Operated cases of hydrocele is disqualifying, if more than 3 months may be accepted, provided there is no post-operative complication.
c) Operated case of Varicocele can be accepted if surgery has been done 180 days back.
d) History of major abnormalities or defects of the genitalia, such as a change of sex, hermaphroditism, pseudo-hermaphroditism, or pure gonadal dysgenesis or dysfunctional residuals from surgical correction of these conditions is disqualifying.

XIII. Examination of heart & vascular system



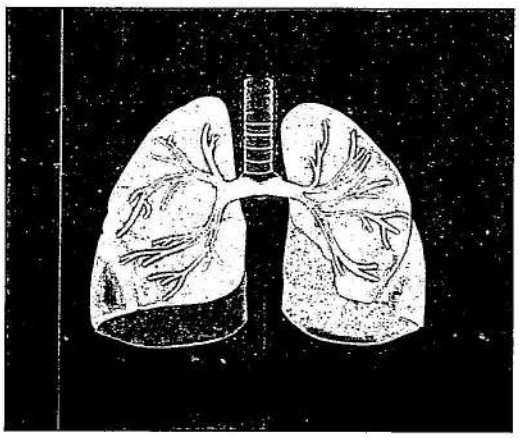
1. Examination of pulse: The pulse should be examined at rest. He/she is made to hop 25 times and pulse rate is again recorded immediately after hopping and 02 minutes after hopping. In normal conditions his/her pulse rate will increase after hopping and normalize after 02 minutes. Failure of pulse rate, not rising with exercise will indicate disease of conduction system like sick sinus syndrome. Similarly, resting pulse persistently over 100 should be kept under observation for some time and re-examined subsequently next morning. Candidate with persistent tachycardia (more than 100 pulse rate per minute) or bradycardia (less than 50 per minute) will be declared disqualified. In case of irregular pulse, the heart should be auscultated for extra systoles and if found the candidate is to be rejected.

2. Examination of Blood Pressure (Normal Range Systolic 100-140 mm of Hg, Diastolic 60 to 90 mm of Hg): Candidate should not be rejected on the basis of single high reading. In case the blood pressure is recorded to be higher than 140 mm systolic and/or 90 mm Hg diastolic, at least 2 more recordings should be taken in lying position at an interval of 2-3 hours before declaring him unfit. BP should be recorded in both arms. The candidate should be asked to relax and should not be subjected to

strenuous/stressful activity immediately prior to the record. (Elevated blood pressure defined as the average of three consecutive sitting blood pressure measurements separated by at least 10 minutes, diastolic greater than 90 mm Hg or systolic pressure measurements greater than 140 mm Hg) is disqualifying.

3. Examination of Heart: Candidates should be examined for cardiac murmurs initially at rest. All the four areas, i.e. Mitral, Aortic, Pulmonary and Tricuspid area should be auscultated. The candidate is then made to undergo exercise by hopping for 25 times and again the heart is auscultated for cardiac murmur or any other adventitious sounds and if found to be pathological, are to be rejected.

XIV. Examination of lungs, pleura & mediastinum



Following are the causes of rejection:

1. Evidence of Asthma, including reactive airway disease, exercise-induced bronchospasm, or asthmatic bronchitis, reliably diagnosed (Reliable diagnostic criteria may include any of the following elements: substantiated history of cough, wheeze etc.)
2. Evidence of bronchitis, acute or chronic.
3. Evidence of bronchiectasis.
4. Evidence of pleurisy with effusion within last 2 years.
5. Tuberculosis:
    a. Evidence of active tuberculosis in any form or location is unfit.
    b. Cases of treated tuberculosis along with normal pulmonary functions will be accepted as fit.

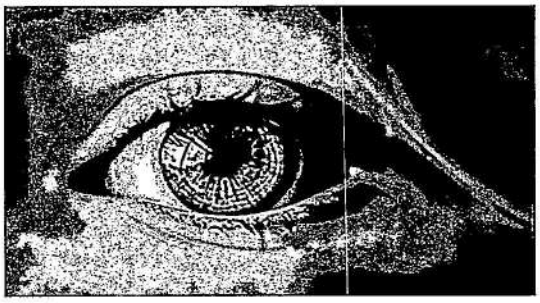
XV. Examination of abdomen

Conditions which entail rejection:

1. Meckel's diverticulum, if surgically corrected within 6 months.

2. Cholecystectomy is not disqualifying if performed more than 6 months back.
3. Enlargement of the liver from any cause.
4. Evidence of splenomegaly.
5. Evidence of splenectomy.

XVI. Examination of eyes



A. VISUAL STANDARD TABLE-I

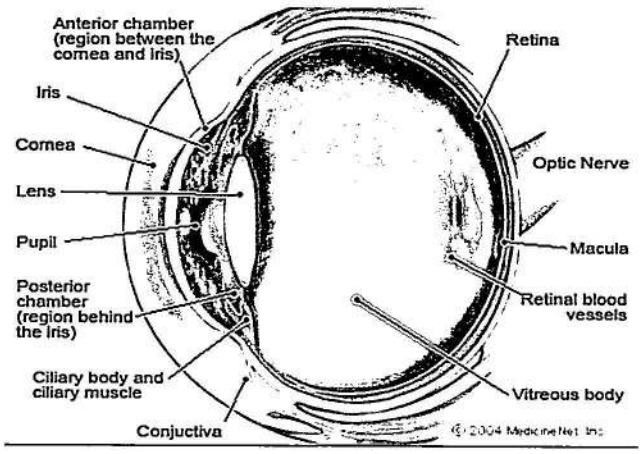
Posts	Near vision	Distant vision	Colour Vision	Eye Surgery
Ct.(Exe), HC(AWO/TPO), Ct.(Driver), Ct.(Mounted), Ct.(Dog Handler), Ct.(Bandsman) and Ct.(Buglers), HC(Ministerial), Clerical nature posts, Technical posts, Computer cadres and all Delhi Police posts. (except MTS)	Better eye- N6 Worse eye-N9 (Without glasses & without any correction)	Better eye-6/6 Worse eye-6/9 (Without glasses & without any correction)	CP III Ishihara Book Test. May misread some of the plates from Plate1-17 and plate 18-21 but plates 22-25 are to be read correctly (one figure is clearer than the other).	LASIK eye surgery shall be permitted subject to candidate being put to following tests and declared fit based on results: i. Contrast sensitivity ii. Dim light vision (Mesopic vision) iii. Glare acuity The medical report prepared on the basis of the above tests shall decide the visual standards as per the norms, thereby declaring fit or unfit.

B. OPHTHALMIC SYSTEMIC EXAMINATION

I. Introduction

Visual defects and systematic ophthalmic conditions are among the major causes of rejection and hence a thorough and accurate eye examination is of great importance in selecting personnel.

To reduce observer error and ensure maximum reliability, certain examination techniques are recommended.



The examination is to be conducted in the following five stages:

a. History
b. General external examination of the eyes and their adnexae.
c. Determination of visual acuity for distance and near vision and proper examination to assess colour vision.
d. Ocular adjustment by doing muscle balance tests.
e. Fundi, field, slit lamp examination and other examinations, as required.

II. Scope: This document lays down methods of examination to be followed for selection of recruits. As a general rule, medical examiners are required to examine the ophthalmic system only to the extent possible with the instruments that will always be available to them. This will include a vision testing box and a torch without facilities for magnification.

III. General External Examination of the Eyes and their Adnexae:

a. Lids, lashes and lacrimal apparatus: Any ptosis, blepharitis, or abnormal condition of the lachrymal apparatus should be noted. Ptosis interfering with vision or visual field is a cause for rejection till surgical correction remains successful for a period of six months. Mild ptosis of less than 2 mm if not associated with any signs aberrant regeneration or head tilt and not interfering with vision should not be a cause for rejection. Candidates with uncontrollable blepharitis,

particularly with loss of eyelashes, are generally unsuitable and should be rejected. Naso-lacrimal occlusion producing epiphora or a mucocele entails rejection, unless surgery produces relief lasting for a minimum of six months. This is to be confirmed with syringing prior to endorsing fitness.

b. Conjuctiva: The bulbar and palpebral conjunctiva, including the fornices, should be examined for signs of hyperaemia, infection or growth.
c. Pterygium: Pterygium may be of a progressive nature and it is often difficult to decide the nature of a pterygium on one examination. The criteria for labelling a pterygium as progressive will be as follows:
    a. > 2 mm extent into cornea.
    b. Causing Irregular astigmatism.
    c. Vascular leading edge.

Conjunctival pathology such as papillae, limbal follicles and embroyotoxon suggestive of vernal keratoconjunctivitis will be a cause of rejection since this is a chronic and recurrent condition.

Bitot's spots: Bitot's spots are not a cause for rejection except when they are accompanied by clinically significant dry eye in the form of reduced schirmers test or reduced tear film break up time, punctuate fluorescein staining of the cornea, obvious symblempharon formation or keratomalacia and corneal epithelial defects.

i. Cornea and Anterior Chamber: The presence of corneal opacities, vascularization, radial scars or scars of operations should be carefully noted. Depth and contents of anterior chamber should also be noted. Also look if the individual is wearing contact lenses.
ii. Corneal opacities: The existence of isolated peripheral corneal opacities, considered in the opinion of the ophthalmologist to be stationary and unlikely to recur, should not be a cause for rejection, except in cases that are of a borderline nature. For example, a partial thickness post traumatic peripheral corneal opacity is unlikely to recur and trouble the individual in his service career and should not be a cause for rejection. As a guideline, opacities of any size or grade not encroaching upon the central 6 mm of the cornea (pupillary size in a darkened room approx. 5 to 6 mm) should not be a cause of rejection provided they are not indicators of diseases of a recurrent or progressive nature. Diseases of a chronic or progressive nature could include keratoconus,

corneal dystrophies, herpetic corneal disease and other such disorders.

IV. Cataract: Lenticular opacities that are compromising vision in the opinion of the ophthalmologist or are likely to progress or need treatment early in the individual's career, will be a cause for rejection.

1. Iris and Pupils: Any abnormality of colour or configuration of the iris, or signs of past iritis should be noted. Any inequality of the pupils should be noted e.g. mydriasis, miosis, or irregularity due to posterior synechiae. Any abnormal reaction to light or accommodation / convergence should also be noted. Pupils should be equal, circular, and moderate in size and reach to light promptly. RAPD (Relative afferent pupillary defect) is a cause for rejection since it implies optic nerve injury. Pupillary reactions are to be tested with the individual looking into the distance with the room lights off and with the brightest available light source. Light should be projected into one eye and kept on the eye for three seconds and the reaction of the pupil noted. The same is repeated with the other eye. The swinging flashlight is done next with light swinging from eye to eye with the same three second duration of exposure.
   Interpretation:
   a. Direct reaction - both eyes react equally and briskly. Swinging flashlight test - both pupils react equally, no dilation when light is reapplied to any eye - this is a normal reaction.
   b. Direct reaction - both eyes react (may or may not be equally). Swinging flashlight test - one pupil reacts briskly, the other pupil dilates upon application of light - this is an unequivocal RAPD - reject.
   c. Direct reaction - both eyes react (may or may not be equally). Swinging flashlight test - one pupil reacts briskly, the other pupil constricts initially and then dilates but does not return to the same size as the constricted pupil of the contralateral eye. - This is a lower grade of RAPD. Retest till you are convinced that the pupil in the involved eye does not attain the same size of the constricted pupil of the other eye.
   d. Direct reaction - both eyes react but the pupil shows alternating dilating and constricting movements. Swinging flashlight test - both pupils show the same alternating constriction and dilation and the smallest size pupil size attained is the same in both eyes. This is hippus - It is a physiological condition, to be considered fit. Any signs to suggest uveitis will entail rejection.

2. Ocular Movements: The eyes should move fully and normally in all directions and no diplopia should be elicited in any quadrant. Particular attention should be paid to candidates with torticollis, because to abolish diplopia and maintain binocular single vision, individual may adopt a head tilt.
3. Nystagmus: Special care should be taken particularly to keep the fixation object inside the normal binocular field of vision. Physiological nystagmus can almost invariably be demonstrated in extreme positions of gaze, or if the fixation object passes from the view of one eye behind the nose. Latent nystagmus is demonstrated by covering one eye. Differentiation of the type of nystagmus is given below.

S. No.	Type of pointing	Vision	Slow and quick component	Any Position	Occurrence accompanied by Vertigo	Past Extreme Position
1.	Physiological	Not diagnostic	No	Yes	No	No
2.	Ocular	Bad	No	No	When attempting fix	No
3.	Extra-ocularparesis	Not diagnostic	Usually	In direction of action of the paralysed muscle	No	No
4.	Central	Not diagnostic	Usually	In direction of action of the paralysed muscle	No	Yes
5.	Labyrinthine	Not diagnostic	Yes	No	Yes	Yes

4. Distant Vision: Distant visual acuity is judged by standard test types, read by each eye separately first, and then together without glasses at 6 meters. Digital, Auto projector charts should be used, if possible. The test type should be illuminated to the minimum of 10 feet candles (9-18 W standard company Tube light fitted). If the illumination is less, the visual acuity cannot be assessed correctly. Distance between the candidate and the test type should be exactly 6 meters. The lettering in the test should not be faded and must be against clear white background.

   While checking the vision in either eye, the trial frame can be employed, which should be light and readily adjustable. It should be corrected and adjusted to ensure that it is accurately fitted to a

symmetrical fact. The eye that is not being tested should be occluded with opaque card without pressure.

In the Snellen's test type of charts, the distance at which a particular letter should be read by a person with standard vision is given that letter. For example, if a person at 6 meters can read only the letter that is to be read from 60 meters (marked 60 against that letter on the chart), his vision is recorded as 6/60. Similarly, 6/36, 6/24, 6/18, 6/12, 6/9 or 6/6 is recorded according to the number on the smallest line read. If he cannot even read the largest at 6 meters, the distance is reduced by a meter each time till he can read the top letter. If he reads it at a distance of 1 meter, his vision is recorded as 1/60. If his vision is less than 1/60 finger counting close to the face is checked. If even finger counting is not possible, then his ability to recognize hand movement (HM) is recorded. If even hand movements are not appreciated then his perception of light (PL) projected from four quadrants is tested and recorded.

The chart should be changed frequently to obviate the possibility of candidate having memorized the chart. Alternatively, Landolt's broken ring chart may be used. To prevent memorizing, the candidate can be asked to read any line in the reverse direction (right to left). The individual can also be asked to read alternate letters in reverse to ensure that letters are not memorized. Special attention is to be paid to ensure that candidates not be allowed to squeeze their eyes during the examination.

5. Astigmatic individuals may be able to read letters indistinctly or may misidentify them because of indistinct image on the retina. There may be desire to tilt the head to one side for better focus. Such individuals may be tested with cylindrical lens or stenopic slit.

6. Method of Recording when Lines are Read Partially: If a person reads 5 letters out of 7 correctly, say in 6/6 line, his vision will be recorded as 6/6. In case he reads less than 5 letters, the vision should be recorded as he has read the larger letters in the line above. Where the individual has read only 4 letters and cannot see the 5^{th} letter distinctly, he should be given the benefit of trial of another chart, where he may be able to read 5 letters. Recording of vision as - Partial (P) is not permitted. The recording then should be reset when full reading is correct, say 6/9.

V. Refraction: Refraction must be done with a streak retinoscope with adequate illumination and a fully open aperture. The candidate must be under cycloplegia with cyclopentolate or homatropine and minimum of 1 hour is to elapse from the time of instillation of drops to the time of

refraction. Autorefraction readings are NOT ACCEPTABLE for purposes of medical examination. Findings of refraction are to be recorded on the medical examination form in the conventional manner. This test is not to be done for recruits at the initial stage and can only be done by an ophthalmologist at the time of appeal, if deemed necessary.

7. Near Vision: For recording near visual acuity, Snellen's or Jaeger test types are used. The candidate is seated in a chair with good light coming from behind the left shoulder and is asked to hold the card at approximately 30 cm distance and asked to read the words and sentences. The number of the smallest type printed on the card that he can read comfortably is the near vision. It is recorded as NV=N5, if he reads the smallest print marked 5.

8. Manifest Hypermetropia: In cases of hypermetropia, the total hypermetropia can be divided into two parts; latent hypermetropia that is overcome physiologically by the tone of the ciliary muscle and manifest hypermetropia. Manifest hypermetropia is again divided into facultative hypermetropia that is overcome by an effort of accommodation and absolute hypermetropia that cannot be so overcome.

9. Procedure for testing Manifest Hypermetropia: The candidate is seated at 6 metres from the test types, and wears a trial frame with a plus 2.00 D SPH lens in each eyepiece. He is asked to read 6/6 line with both eyes. If he is able to read without seeing the letters blurred or distorted, manifest hypermetropia of 2.00 D SPH is present. To assess the amount of manifest hypermetropia, the strongest convex lens in front of the eyes with which clear vision is still maintained (6/6 clearly), is recorded. Wherever possible and necessary, refraction is done under cycloplegia and reading for manifest hypermetropia is taken.

10. Colour Vision: Colour perception of an individual does not alter during life except rare cases of injury and disease. Colour blindness is usually congenital, affecting both eyes and the functions of the eye are otherwise normal. Acquired colour blindness is often found in diseases of retina and optic nerve, toxic retino neuropathy being the commonest causes. Colour perception is based on Martin Lantern Tests and Ishihara Book charts.

11. Colour perception standards are CP I, CP II, CP III and CP IV.

12. CP I Candidate capable of identifying without hesitation all colours shown through the small apertures of the Martin's Lantern at 6

meters in a perfectly darkened examination room. In addition, the candidate must pass Ishihara Book Test.

13. CP II Candidate passes Ishihara Book Test, as specified in paras 19 and 23 respectively.

14. CP III (Colour Defective Safe): Candidate who recognizes white, signal red and signal green colours by large apertures shown by Martin's Lantern at 1.5 meters correctly or reads the requisite plates on Ishihara Book as given in paras 19 and 23 respectively.

15. CP IV (Colour Defective Unsafe): Unable to recognize white, signal red and signal green colours shown by Martin's Lantern by large apertures at 1.5 metres correctly or unable to read plates 2-9 and 22-25 on the Ishihara Book.

16. CP V (Colour Perception Defective Absolute or Colour Blind): Candidates unable to read any colour plate in Ishihara Book and will recognize only grey and white colours. In true sense such person will be declared as totally Colour blind in the true sense. It is further mentioned at paras 24 and 25 respectively.

VI. Method of examination and assessment of Colour Vision

17. Martin Lantern Test. This test is very sensitive when properly carried out and it detects anomalous trichromates who are likely to pass even on Ishihara at times. Such cases appear normal at most times and are rarely aware of their deficiency, the defect becoming manifest under favorable conditions.

18. Assessment: Correct answering by the candidate, without hesitation, including the series of colours shown with the pair of small apertures, will be interpreted as Colour Perception Standard 1 (CP I).

19. Candidates who fail to be placed in CP I are to be graded CP III or CP IV as follows: The candidate will be seated at a distance of 1.5 meters from the Martin Lantern and will be asked to name colours, presented singly with the large aperture, to satisfy the examiner that he can recognize correctly, without guessing, signal red, signal green and white. A candidate who passes the test will be assessed CP III and, if he fails, CP IV. The right-hand aperture of the Lantern is to be occluded by the examiner during the test, leaving only the left aperture exposed. No errors are allowed in this part of the test.

20. Ishihara Book: The book should be held at a distance of 75cm from the candidate. The test should be carried out in ordinary day light, but not directly in the sun. Artificial illumination, if used, will be a tube light with day light filter. No candidate should be rejected unless tested in daylight. Each plate should be shown for 2 to 3 seconds only. Answer given should be noted. Next plate should be shown thereafter. Care should be taken that the charts are not unduly faded or otherwise marked. Candidate should not be allowed to touch the charts. No fixed sequence should be followed to guard against candidate memorizing the book.
    a. These plates are used for screening of all candidates.
    b. The candidates who pass Ishihara Book Test are graded as CP II (Colour Perception Normal) and require no further testing.
    c. The candidates who fail Ishihara Test are further tested for CP III or CP IV according to requirement.
    d. Any person in CP V (Colour Perception Defective Absolute or Colour Blind) is unable to pass any of the tests for CP I to CP IV standard.

21. Assessment: Colour vision assessment by Ishihara book is contained in the succeeding paras.

22. Colour Perception Normal (CP II): The numbers on all plates from plate no. 1-17 and 22-25 should be read correctly. No number should be read on plates 18-21 as they do not have any number.

23. Colour Perception Defective safe (CP III): May misread some of the plates as under:

Plate No.	Actual No.	Read As
2	8	3
3	6	5
4	29	70
5	57	35
6	5	2
7	3	5
8	15	17
9	74	21
18	No number	5
19	-	2
20	-	45
21	-	73

Plates 22-25 are read correctly (One figure is clearer than other)

24. Colour Perception Defective Unsafe (CP IV): The individual is unable to read even plates 2-9 and 22-25. Appropriate trade testing will further discriminate between CP IV and CP V.
25. Colour Perception Defective Absolute or Colour Blind (CP V): Candidates who fail to reach the minimum standard of Colour Perception are to be graded as CP V. The one who can only recognize grey and white colour is in true sense Colour Blind and to be put in CP V standard. Appropriate trade testing (normally using a wire board and stationary tabs of different colours) will discriminate between CP IV and CP V.

26. Night Vision: Night Vision test is not done as a routine. In case the candidate gives family history of night blindness or gives symptoms of night blindness or shows signs suggestive of defective night vision, test is done to assess the night vision capacity at the nearest Eye Centre to rule out organic pathology leading to night blindness. Night vision test - is normally done with apparatus Della Cassa and electroretinogram if required clinically.

27. Ocular Muscle Balance: This examination is conducted to detect Heterophoria or Latent Squint. Heterophoria is the group name for the several types of latent or hidden squints. which are revealed by certain tests described below. A simple classification of Heterophorias as follows:
    a. Exophoria or divergent latent squint - the common type.
    b. Esophoria or convergent latent squint, often associated with a tendency to manifest esotropia and high hypermetropia.
    c. Hyperphoria and Hypophoria, latent upward or downward deviation. uncommon and associated at times with such conditions as ocular torticollis.
    d. Cyclophoria, a rare condition in which the image in the two eyes are tilted at an angle to one another, resulting in a tendency to monocular vision from suppression of one image owing to the impossibility of true fusion.

28. Two types of tests for Heterophoria are carried out. In the first group, the two eyes fix on dissimilar objects, and in the second group, they fix on a common object. Heterophoria for dissimilar objects is tested by the Cover Test.

29. The Cover Test: A suitable cover such as an envelope or card only are required. Both eyes must be tested separately. Prerequisites for cover test are:

- Bilateral macular perception.
- Candidate should be fixing on a distant vision chart.
- Should be done both for distance and near.

VII. Cover test for distance: The individual to be tested is placed 6 meters from a vision chart and told to look at the smallest letter that he can see. Now cover one eye. Watch what happens to the eye that is not covered. If it does not move, then it means that it was already fixating on the object. If it moves to take up fixation, then it means that it was deviated before we applied a cover. Now it is possible that the eye that was covered is normal and remains central behind the cover or it is deviated behind the cover. To find out what the condition is, now remove the cover. Now watch the freshly uncovered eye. If it does not move, then there is no tropia. If it moves to take up fixation, then it means that it was deviated behind the cover we placed and at the same time we will notice that the other eye moved out of fixation. If there is tropia, there will be a visible or suspected deviation before we place a cover. When we place a cover, both eyes will move, one to take up fixation and the other will move out of fixation and when we remove the cover the deviation will persist and both eyes may move again. In case of phorias, there will be no visible deviation before we start the test. No movement when we cover one eye and only one eye (the other where we remove the cover) will move when we uncover the eye. After the test, the eyes will again be aligned.

30. Technique of Cover test for near: Cover one eye completely. Hold the pencil vertically with the point 45 cm from the candidate's face, between his eyes and level with the root of his nose. Ask the candidate to follow its movement with the eye and move the pencil 3 or 4 times across his face, from side to side in a level plane. Range of movement should be approximately 30 cm. Now bring the pencil to rest level with the root of his nose and evenly between his eyes, still at a distance of 45cm from his face. Quickly remove the cover, and observe any movement of previously covered eye.

31. The covered eye may not show any movement or it may move either inwards or outwards. Now the eye, which was open, is covered and the movement of the previously covered eye is once again noted. This part of the test may be termed stage 2. The previously covered eye may once again show no movement or may move either inwards or outwards.

32. Interpretation of Results: If there is no movement of eyeball either in stage 1 or stage 2 of the test, it indicates that the muscle balance

is normal and fusion is achieved with effort. Such a stage is called orthophoria. However, if there was no movement in stage 1 but some movement in stage 2 after covering the other eye, the individual is suffering from heterotropia or manifest squint. If the movement is inwards or outwards in stage 2, the case is diagnosed to suffer from divergent or convergent squint, respectively. If in stage 1 the eye moved inwards and there was no further movement in stage 2, the individual suffers from latent divergence with complete recovery. However, if there was further inward movement in stage 2, he suffers latent divergence with incomplete recovery. In the same way, if the movement in stage 1 was outwards but no further movement occurred in stage 2, the candidate suffers from latent convergence deficiency with complete recovery. In case further outward movement occurred in stage 2. The individual will be deemed to be suffering from latent convergence with incomplete recovery.

33. Whenever the recovery is complete, whether divergent or convergent, the individual suffers from heterophoria. If the recovery was incomplete, he is considered to be suffering from heterotropia.

34. Not only the movement but the rate of recovery is also noted. The recovery can be rapid or slow, immediate or delayed. Now the second eye is tested in similar fashion. The cover test is to be done for distant and near vision separately and mentioned accordingly.

35. Recording of Results. The degree of movement is recorded by letters _ S' if slight and _M' if moderate. Second and third letters indicate lateral or medial deviation. Fourth and fifth letters show rate of recovery and the last two letters indicate whether left or right or both eyes. Slight latent divergence with rapid recovery in both eyes will be recorded as _ SLDRRBE'. Recruits with tropia or manifest squint are unfit. Latent squint is acceptable provided recovery is complete and rapid.

36. Convergence Tests: Convergence is the ability of two eyes to move inwards to focus properly at an object placed near the eye, mainly between the eye and a distance up to one metre. It is a measure of the strength of the two medial rectii one in each eye. Strong medial rectii are necessary for doing any near work and if they are weak the symptoms of eyestrain, headache etc. develop when we do near work for some period of time. Moreover, if the near work is carried

out inspite of eyestrain or headache, the person may suddenly develop diplopia due to relaxation of one of the medial rectii leading to the movement of the weaker eye outward. Hence, good convergence is necessary for comfortable viewing and working at near distance. Convergence insufficiency is not a rare condition and is met with frequently in people having eyestrain.

37. Convergence is divided into two:
    Objective convergence and Subjective convergence.
    a. Objective Convergence: The assessment of convergence is made without taking the help of the individual under examination. It is more reliable and more quickly done.
    b. Subjective Convergence: In assessment of subjective convergence, the assistance of the candidate is taken and it is a good corroborative finding to objective convergence. The test requires special instrument called Livingston Binocular Gauge.

38. Measurement: Both objective and subjective convergence can be measured by Livingston Binocular Gauge/RAF Near Point Rule.

39. Objective Convergence: On the binocular gauge, there is an attachment, a small stick with a pointer. The stick is painted alternately black and white. The stick is placed in the slit of the scale with the pointer running over the centimetre marks. The instrument is placed over the infra orbital margin and the candidate is asked to keep looking at the black and white stick. The stick is then moved towards his nose and the examiner watches the ocular movements of the candidate. The point where one of the two eyes stops moving inwards or suddenly shoots out is taken as the point of convergence. The pointer reading on the scale is noted and is expressed as - convergence: 7 cm. If the reading is very high e.g. beyond 11 to 12 cm, the test should be repeated after explaining to the individual what is required of him/her.

40. The test can also be done with the help of a pencil and scale. The scale is placed below the nose of the candidate and the pencil tips is brought at the level of bridge of the nose. The pencil is then moved towards the nose in contact with marking on the scale and the result noted as explained earlier.

41. Subjective Convergence: This can be done with the help of Livingston Binocular Gauge/RAF near point rule only. The gauge has a box like attachment with the front portion having a cut in the form

of a cross. The back will has an ivory card with a black vertical line and the letters_ ALT' written on either side of it. The card is so placed that the line lies in the middle of the vertical arm of the cross and is seen in the centre of the vertical cut when viewed binocularly. The candidate is instructed to look at the line and inform the examiner when the line shifts either to right or left. The box from the far end is then gradually moved towards the candidate's eye and he informs the examiner as soon as the deflection takes place. The reading is read off from the scale and is noted as SC 18 cm (Rt). Deflection to the right or left denotes the dominant eye for the near. The test becomes unreliable in case of presbyopia.

42. Accommodation: Accommodation is the ability of the eye to bring to focus clearly an object lying between eye and a distance of one meter. Beyond one meter very little accommodation is required. Accommodation is achieved by contraction of ciliary muscle, which in turn relaxes the zonules of the lens and the lens become more spherical and hence more powerful. A child has accommodation up to 7cm. There is a gradual decrease in the power of accommodation with age, which becomes very marked after 30 years of age. This due to hypertrophy of the ciliary muscles and loss of elasticity of lens. which prevents it from taking a new shape. Around the age of 40 years, in an emmetrope, the near point of vision recedes beyond 25 cm and the candidate finds it difficult to read. This condition is called presbyopia and the person requires convex glasses for near vision. The necessity and ability of accommodation is also affected by refractory errors. A myope has much less need for accommodation and a hypermetrope suffers from weak accommodation where he has to be assisted with glasses for reading. One may also suffer from spasm of accommodation, which is associated with variable acuity for distant vision and severe headache.

43. Measurement: Accommodation should be measured independently in each eye. The Ivory card of the binocular gauge and the scale are used. The scale is kept at the infraorbital margin and one eye is closed or covered. The card is kept at about 20 cm from the candidate on the scale. He/ She is instructed to read letter - ALT on the card, to keep looking at the letters and inform the examiner when the letters start blurring. The card is then gradually brought towards the eye and the point where the letters start blurring is noted. It is denoted as - Accommodation Right Eye : 14 cm, Left Eye : 14 cm. To confirm the above, the card is then moved from the nearest position to the eye to the far end with instruction

to the candidate to inform the examiner when he can read letter – ALT.

44. Visual Fields: Visual fields must be normal when examined by hand movements, i.e. confrontation method, each eye being tested separately, as it fixes the eye of the examiner. In case of doubt, perimetry and scotometry or any other test, as felt appropriate, by the examining authority will be carried out. Recruits and candidates will be examined only with confrontation. If a doubt exists about the presence of a scotoma, then automated perimetry will be done.

45. Ophthalmoscopic Examination: Ophthalmoscopic examination is carried out to exclude any abnormality in the fundi and media. Examination must be carried out in a systematic manner starting from the cornea, anterior chamber, pupil, iris, lens, posterior chamber and retina. Note will be taken of reaction of the pupil to the light, abnormality of the papillary edge, any evidence of inflammation of the iris and lenticular opacity. Vitreous floaters are usually of no significance. Any abnormal vascular pattern, muscular scarring, hemorrhage or exudates in the fundi will be noted. The normality of the disc and the vascular pattern in the disc and its edges, AV ratio, papillary oedema or colour change in and around the disc and pigmentary changes elsewhere provide valuable clues to various systemic diseases and must be carefully noted. Indirect ophthalmoscopy is indicated at the discretion of the ophthalmologist and must be carried out when there is a concern about the health of the peripheral retina. Recruits will not be examined by ophthalmoscopy at the initial examination. They will undergo this procedure only upon appeal and if the ophthalmologist feels it is necessary.

46. Myopia: If there is a strong family history of Myopia, particularly if it is established that the visual defect is recent, if physical growth is still expected, or if the fundus appearance is suggestive or progressive myopia, even if the visual acuity is within the limit prescribed, the candidate should be declared unfit.

VIII. Ocular muscle balance:

47. Individuals with manifest squint are not acceptable for recruitment.
48. Any clinical findings in the media (cornea, lens, vitreous) or fundus, which is of pathological nature and likely to progress will be a cause for rejection. This examination will be done by slit lamp and ophthalmoscopy under mydriasis.

IX. Specific conditions:

a. Night Vision: As tests for night blindness are not routinely performed, a certificate to the effect that the individual does not suffer from night blindness will be obtained in every case.
b. Ptosis: Interfering with vision or visual field is a cause for rejection till surgical correction remains successful for a period of six months. Mild ptosis of less than 2 mm if not associated with any signs of aberrant regeneration or head tilt and not interfering with vision should not be a cause for rejection. Candidates with uncontrollable blepharitis, particularly with loss of eyelashes, are generally unsuitable and should be rejected.
c. Pterygium: Pterygium may be of a progressive nature and it is often difficult to decide the nature of a pterygium on one examination. The criteria for labelling a pterygium as progressive will be as follows:
    i. > 2 mm extent into cornea.
    ii. Causing Irregular astigmatism.
    iii. Vascular leading edge.
d. Bitot's spots: Bitot's spots are not a cause for rejection except when they are accompanied by clinically significant dry eye in the form of reduced schirmers test or reduced tear film break up time, punctuate fluorescein staining of the cornea, obvious symblempharon formation or keratomalacia and corneal epithelial defects.
e. Naso-lachrymal occlusion: Producing epiphora or a mucocele entails rejection, unless surgery produces relief lasting for a minimum of six months. This is to be confirmed with syringing prior to endorsing fitness.
f. Corneal opacities: The existence of isolated peripheral corneal opacities, considered in the opinion of the ophthalmologist to be stationary and unlikely to recur, should not be a cause for rejection or referral to Sr. Adviser, except in cases that are of a borderline nature. For example, a partial thickness post traumatic peripheral corneal opacity is unlikely to recur and trouble the individual in his service career and should not be a cause for rejection. As a guideline, opacities of any size or grade not encroaching upon the central 6 mm of the cornea (pupillary size in a darkened room approx. 5 to 6 mm) should not be a cause of rejection provided they are not indicators of diseases of a recurrent or progressive nature. Disease of a chronic or progressive nature could include keratoconus, corneal

dystrophies. herpetic corneal disease and other such disorders.

g. Cataract: Individuals with congenital cataracts such as blue dot cataracts and other lenticular opacities that do not decrease visual acuity and are known to be non-progressive should be deemed fit by local ophthalmologists upon first examination. These cases should invariably not be sent for Sr. Adviser opinion except in cases that are of a borderline or controversial nature. Those lenticular opacities that are compromising vision in the opinion of the ophthalmologist or are likely to progress or need treatment early in the individual's career, will be a cause for rejection. In general, opacities outside the central 7 mm zone are not to be considered a cause for rejection if visual acuity is unaffected.

h. Uveitis (iritis, cyclitis, and choroiditis) is frequently recurrent, and candidates giving a history of or exhibiting this condition should be carefully assessed. When there is evidence of permanent lesions such candidates should be rejected. Stigmata such as raised Intraocular pressure, visible keratic precipitates, posterior synechiae, goniosynechiae, lenticular opacities, vitreous opacities or cystoid macular edema will be a cause for rejection.

i. Glaucoma: Since this disease is progressive throughout life, individuals with glaucoma will be deemed unfit. The criteria for diagnosis of glaucoma will be IOP< 24 mm Hg after correction for corneal thickness, glaucomatous disc configuration and a corresponding field defect satisfying Andersens criteria on a 30-2 or 24-2 visual field.

j. Cataract Surgery: The advance of technology in ophthalmology results in excellent visual outcomes after cataract surgery and has returned a large number of servicemen to active duty. The disposal of these cases needs to be reviewed. This surgery is capable of excellent refractive and structural outcomes with stabilization of ocular status in one month after surgery in the uncomplicated case. However, individuals that have undergone these surgeries are at long term risk for lens pacification, retinal detachment and glaucoma since, at this age, most of these surgeries would be done in eyes with trauma or other diseases.

X. Retinal diseases:

a. Any retinal degenerations such as typical Lattice degeneration even with retinal holes, white without

pressure, microcystoid degeneration or Paving-stone degeneration will require referral to a senior adviser or a retinal surgeon for fitness. Reasons for rejection for lattice degeneration will include:

i. Family history of retinal detachment.
ii. Axial length more than 26 mm.
iii. Refractive error more than 6 Dioptre.
iv. Lattice with horseshoe tears.

b. History of retinal detachment, vitrectomy for any reason, and scleral buckling or laser therapy for any reason (except lattic degeneration without horseshoe tears) will be a cause for rejection.
c. Retinal scars or chorioretinal atrophy in a non-macular area with normal vision and no evidence of inflammation or vitreoretinal traction will not be a cause for rejection. Amsler charting and visual fields will invariable be done in these cases to demonstrate integrity of the central visual field and impact of the scotoma resulting from the scar.
d. Evidence of any retinal dystrophy will be a cause for rejection.

Coloboma: Colobomas of the eye are grounds for rejection since they greatly increase the chance of retinal detachment up to 40%. Hence individuals with Colobomas will invariably be declared unfit. Colobomas restricted to the iris may be considered fit provided the individual does not have microphthalmos, squint and satisfies the visual acuity criteria.

4. MISCELLANEOUS CONDITIONS:

a. Any evidence of implants in situ anywhere in body will lead to rejection.
b. Gynaecomastia: Gynaecomastia means enlargement of tissues in male's breast due to hormonal imbalance. It will lead to rejection in the initial medical examination, if the diameter of the mass is more than 4 cm. During review medical examination, ultrasound examination is to be done to rule out whether it is due to fatty tissue or breast tissue. Candidates are to be rejected if found to have breast tissue.
c. Tattoo: Permitted subject to following conditions:
    i. Permitted only religious symbol, figure or name.
    ii. Tattoo is allowed on left hand forearm and inner aspect of forearm or dorsum of the hand and on the concealed part of the body while in uniform.
    iii. Size must be less than one-fourth of the particular part (elbow or hand) of the body. However, if the

tattoo is on the concealed part of the body, size and symbol does not matter.

d. Post-operative cases:

S. No	Post-operative cases	Duration of fitness
1.	Body surface swelling, DNS, tonsillectomy, and nasal polypectomy	01 month
2.	Hydrocele	03 months
3.	Tympanoplasty	04 months
4.	Abdominal/Pelvic surgeries involving opening of peritoneum, repairs of Hernia, varicocele surgeries, surgery for fistula-in-ano etc.	06 months

e. Evidence of nervous instability: Attention should be paid to manifestation of nervous instability such as Restlessness, Tachycardia, Tremors, Rombergism, Hyperhidrosis, Prominence of eyes or enlargement of the thyroid etc. In case the nervous instability seems to be due to anxiety, the candidate is to be kept under observation for some time and then re-examined. If the signs persist the candidate is to be rejected.

5. INVESTIGATIONS

Following investigations are to be carried out:

a. Hemoglobin
b. Urine Examination- Routine and Microscopic
c. Chest X-ray

Hemoglobin:

(Normal Range – 12 – 16 gm% for male, 10 – 14 gm% for female).

However, candidates with more than 18 gm% will be considered unfit.

Hemoglobin below 12 gm% for male and below 10 gm% for female will be considered as disqualified.

Urine Routine/Microscopic:

i. Presence of Sugar.
ii. Presence of protein above trace limit.
iii. Presence of blood: Any presence of RBC will lead to rejection in male; physiological cause to be ruled in case of female.
iv. Specific gravity: Any variation from the range 1.000 – 1.030 will lead to rejection.

Chest X-ray PA:

i. Evidence of chronic inflammation, e.g., fibrotic/nodular opacity, cavities, dilated bronchi, puckering/blunting of diaphragm.
ii. Any non-homogeneous lung opacity.
iii. Evidence of damage or shifting of mediastinal organs.
iv. Evidence of foreign body or medical device.
v. Collapse of any mediastinal organ.
vi. Blunting of cardio-and/or costophrenic angle.
vii. Cervical rib, if symptomatic.
viii. Damage/degeneration of cervico-dorsal spine.
ix. Evidence of fracture, with features of mal-union, non-union or functional disability.
x. Presence of any space occupying lesion.
xi. Evidence of pericardial effusion.
xii. Any opacity in the lung field more than 1 cm in diameter.
xiii. Signs of eventration of diaphragm.
xiv. Bilateral 13th rib.
xv. Evidence of cardiomegaly with cardio-thoracic ratio more than 50%.
xvi. Dilated right descending pulmonary artery more than 15 mm dia in female and more than 16 mm dia in male.
xvii. Any tumor of the bone.

6. VALIDITY OF MEDICAL EXAMINATION

The findings/opinion of the recruitment medical board will be valid for one year from the date of fitness to joining the service. If, the candidate joins the service after validity period of recruitment medical, he/she will be subjected to fresh medical examination before joining the service.

7. CERTIFICATE OF FIT/UNFIT

After having satisfied himself that the candidate is fit/unfit, the medical examiner should issue certificate for fit candidates (Annexure IV) and unfit candidates (Annexure V) in this regard.

8. CONSENT FORM FOR RME

A consent form for candidates found unfit in DME for conducting their Review Medical Examination is placed at Annexure VI.

9. RME FORM

Review Medical Examination form is placed at Annexure VII.

10. GUIDELINES FOR REVIEW MEDICAL EXAMINATION

Candidates declared unfit during detailed medical examination may avail the option of Review Medical Examination and such RME should be got done by the

appellate authority within a period of 15 days from the date of medical examination.

a. Review Medical Board should examine the candidate specifically for the deficiency for which the candidates have been declared unfit. However, for obvious defects /infirmities contracted after Detailed Medical Examination, Review Medical Board may give its opinion. Also, the medical term used as cause of unfitness during the Detailed Medical Examination may differ from the one arrived at by the Review Medical Board after due investigations and specialist consultation.
b. The Review Medical Board shall not give opinion in a cursory manner and its findings must be supported by proper investigation reports if applicable. Review Medical Board may get opinion of concerned specialists or super specialists of Govt. Medical College / Govt. Hospital.
c. The procedure adopted during Detailed Medical Examination under the specified guidelines should be referred to by the Review Medical Board to give the final opinion.
d. If a candidate is declared medically unfit on account of visual acuity, his/her RME board shall have three ophthalmologists and the findings of this board shall be considered final.

****

Divya 25/07/24
W/PSI Divya Dagar
DPA/JK

akumar
SI Rohit Kumar
Rectt. Cell / PHQ

ACP Johny Anto
Rectt. Cell / PHQ

Dr. Rajneesh Garg
DCP / Licensing
(Member)

25/7/24
Satya Vir Katara, IPS
Addl. CP / Recruitment
(Member)

Asif Mohd. Ali, IPS
Joint Director / DPA
(Member)

Ajay Chaudhry, IPS 25/7/24
Spl. CP / AP Div. &SPUWAC / SPUNER
(Chairman)

ANNEXURE-I

Male Average Body Weights in Kilograms for different Age Groups and Heights

HEIGHT IN CMS	AGE IN YEARS			
	18-22	**23-27**	**28-32**	**33-37**
158	45-55	47-57	48.5-59.5	49.5-65
160	46-56	47.5-58.5	49.5-60.5	50.5-61.5
162	47-58	49-60	50.5-61.5	52-63
164	48-59	50-61	52-63.5	53-65
166	49.5-60.5	51.5-62.5	53-65	54.5-66.5
168	51-62	52.5-64.5	54.5-66.5	56-68
170	52-64	54-66	56-68	57.5-70.5
172	54-66	55.5-67.5	57-70	59-72
174	55-67	57-70	59-72	61-74.5
176	56.5-69	58.5-71.5	60.5-73.5	62-76
178	57.5-70.5	60-73	61.5-75.5	63.5-77.5
180	59-72	61-75	63.5-77.5	65.5-80
182	61-74.5	62.5-76.5	65-79	66.5-81.5
184	63-77	64.5-78.5	66.5-81.5	68.5-83.5
186	63.5-77.5	65.5-80.5	68-83	70-86
188	65-79	67.5-82.5	70-85.5	71.5-87.5
190	66-81	68.5-83.5	70.5-86.5	72.5-88.5

Female Average Body Weights in Kilograms for different Age Groups and Heights

HEIGHT IN CMS	AGE IN YEARS			
	18-22	**23-27**	**28-32**	**33-37**
150	36.5-44.5	37.5-45.5	39-48	40.5-49.5
153	38-46	39-48	41-50	42-51
155	38.5-47.5	40-49	41.5-50.5	43-52.5
158	40.5-49.5	42-51	43-53	44.5-54.5
160	41.5-50.5	43-52.5	44-54	45.5-54.5
163	43-52.5	44-54	46-56	47-57
165	44-54	45.5-55.5	47-58	48.5-59.5
168	45-55	47-57	48.5-59.5	49.5-60.5

- The body weights are given in this chart corresponding to only certain height (in cm) on even numbers only. In respect of heights in between, the principle of 'Average' will be utilized for calculating body weights.
- In doubtful cases of overweight, the assessment is to be made on the basis of BMI.
- Where Age for Govt. employees is relaxed above the age of 37 (for example, 40 or more) the average weight be arrived by using BMI.

ANNEXURE-II

DECLARATION FORM

The candidate must make the statement required below prior to his/her medical examination and must sign the declaration appended thereto. His/her attention is specially drawn to the warning contained in the note below:

Note: The candidate shall be held responsible for the accuracy of his/her statement. By wilfully suppressing any information, he/she may incur the risk of losing the appointment, and, if appointed, of forfeiting all claim to superannuation allowance or gratuity.

(GOI: MH O.M. No. F 5 (II)-55-M-II dated the 27th September 1957)

Roll number- Name-

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

Sl. No.	CONDITIONS	YES	NO
1.	Asthma, wheezing or inhaler use.		
2.	Epilepsy, fits, seizures or convulsions		
3.	Recurrent neck or back pain or ruptured or bulging disc in your back or surgery for a ruptured or bulging disc.		
4.	Evaluation, treatment or hospitalization for substance use, abuse, addiction or dependence.		
5.	Foot pain		
6.	A swollen, painful, or dislocated joint or fluid in a joint or any problem or surgery of any joint.		
7.	Surgery on a bone or joint (knee, shoulder, elbow, wrist etc)		
8.	Locking or giving way of knee or other joint.		
9.	Episode of unconsciousness or Fainting spells.		
10.	Wear contact lenses or undergone LASIK or any kind of other eye surgery.		
11.	Night blindness		
12.	Head injury, including skull fracture, resulting in concussion, loss of consciousness, headache etc.		
13.	Seen a psychiatrist, psychologist, social worker, counsellor or other professional for any reason (in patient or outpatient) including counselling or treatment for any problem including depression or treatment for alcohol, drug or substance abuse.		
14.	Irregular heartbeat, including abnormally rapid or slow heart rates.		
15.	Been placed in LMC ever (for department candidates only) or rejected earlier in any medical examination.		
16.	Hepatitis (liver infection or inflammation)		

17.	Jaundice		
18.	Leprosy in you or your family.		
19.	Intestinal obstruction (locked bowels), or any other chronic or recurrent intestinal problem, including small intestine or colon problems, such as Crohn`s diseases or colitis.		
20.	Surgery to remove a portion of the intestine.		
21.	Gall bladder trouble or gall stones		
22.	Missing a kidney or any problem of kidney, urinary tract or bladder or any surgery or any stone or other urinary tract problems.		
23.	Broken bone (Fracture(s))-united without any surgery or required surgery to repair.		
24.	Thyroid condition or taking medication for your thyroid.		
25.	Sugar, protein or blood in urine.		
26.	Perforated ear drums or discharge from ears.		
27.	Ear surgery to include mastoidectomy or repair of perforated ear drum, hearing loss or need/use a hearing aid.		
28.	Any history of taking treatment under alternative medicine systems like homoeopathy, ayurveda, unani, siddha, naturopathy etc. and for what.		
29.	Taking any medication, if so for what.		
30.	Any illness, surgery or hospitalization not listed above.		
31.	Any other type of surgery.		
32.	Any family history of any disease.		
33.	Any chronic disease in the past.		
	For female candidates only		
34.	Whether pregnant or not?		
35.	History of irregular menstrual period?		
36.	History of any abnormal vaginal discharge.		
37.	History of any abnormal gynaecological investigations.		
38.	History of any gynaecological surgery.		
39.	History of breast pain/lump or discharge from the nipple.		

Signature of Candidate

(NAME IN CAPITAL)

Contd.....

Furnish the following particulars concerning your family:

Father' age, if living, and state of health.	Father's age at death, if dead, and cause of death.	No. of brothers living, their ages and state of health.	No. of brothers dead, if any, their ages at death and cause of death.

Mother's age, if living, and state of health.	Mother's age at death, if dead, and cause of death.	No. of sisters living, their ages and state of health.	No. of sisters dead, if any, their ages at death and cause of death.

After having fully understood all above medical terminologies, I declare that all the above answers to the best of my belief and knowledge, are true and correct. I also solemnly affirm that I have not received disability certificate/pension on account of any disease or other condition. I shall be liable for action under law for any material infirmity in the information furnished by me or suppression of relevant material information. The furnishing of false information or suppression of any factual information would be a disqualification and is likely to render me unfit for employment under the Government. If the fact that false information has been furnished or that there has been suppression of any factual information comes to notice at any time during the service, my service would be liable to be terminated.

Place----------

Date---------- **(Candidate's Signature)**

(NAME IN CAPITAL)

Signed in my presence

(Signature of Presiding Officer with stamp)

ANNEXURE III

OFFICE OF THE DEPUTY COMMISSIONER OF POLICE: RECRUITMENT CELL, NEW POLICE LINES, KINGSWAY CAMP, DELHI-110009

DETAILED MEDICAL EXAMINATION FORM

Roll No. .....

Date of medical .....

Candidate's Signature

Post applied for.....

CANDIDATE'S STATEMENT AND DECLARATION

The candidate must make the statement required below prior to his/her medical examination and must sign the declaration appended thereto. His/her attention is specially directed to the warning contained in the Note below:

Candidate's photo

1. Name in full (in block letters) .....

2. Father's name .....

3. Date and Place of birth .....
.....

4. (a) Have you ever had smallpox, intermittent or any other fever, nlargement or suppuration of glands. Spitting of blood, asthma, heart disease, lung disease, fainting attacks, rheumatism, appendicitis? .....

Or

(b) any other disease or accident requiring confinement to bed and medical or surgical/treatment? .....

5. When were you last vaccinated? .....

6. Have you or any your near relations been affected with consumption/tuberculosis scrofula, gout, asthma, fits, epilepsy or insanity? .....

7. Have you suffered from any of nervousness due to over work or any other cause? .....

8. Have you been examined and declared unfit for Govt. service by a medical officer/ medical board, within the last three years? .....

9. Furnish the following particulars concerning your family:

Contd....

Mother's age of living & state of health	Mother's age at death and cause of death	No. of sisters living their ages and state of health	No. of sisters dead their ages at death and cause of death

Father's age of living & state of health	Father's age at death and cause of death	No. of brothers living their ages and state of health	No. of brothers dead their ages at death and cause of death

I declare that all the above answers to the best of my belief are true and correct.
I also solemnly affirm that I have not received disability certificate/pension on account of any disease or other condition. I declare that I have never been pronounced unfit for Govt. employment by a medical board or any other duly constituted medical authority.

Note:- The candidate shall be held responsible for the accuracy of above statement. By willfully suppressing any information, he/she will risk of losing the appointment and if appointed forfeiting all claim to superannuation allowance or gratuity.

Signature .....

Roll No. .....

Name .....

Father's name .....

Address .....

Date .....

Contd.....

FORM OF MEDICAL EXAMINATION

1. General development: Good ..... Fair ..... Poor .....
2. Nutrition ..... Thin ..... Average ..... Obese .....
3. Weight .....
4. Temperature .....
5. Skin: Any obvious disease .....
6. Eyes:
   - (i) Any disease .....
   - (ii) Night blindness .....
   - (iii) Defect in colour vision .....
   - (iv) Field of vision .....
   - (v) Fundus examination .....

Acuity of vision	Naked eye	With glasses	Strength of glasses		
			Sp.	Cyl.	Axis
Distant Vision : R.E. L.E.					
Near Vision : R.E. L.E.					

7. Ears
   Inspection ..... Hearing: Right Ear ..... Left Ear .....
8. Speech
   Normal Speech ..... Speech Disorder .....
9. Glands ..... Thyroid .....
10. Condition of Teeth .....
11. Circulatory system
    - (a) Heart ..... Any organic lesions?
      Rate ..... standing
      After hopping 25 times .....
      After hopping for 2 minutes .....
    - (b) Blood pressure Systolic ..... Diastolic .....

Contd.....

12. Abdomen

Girth ..... Tenderness ..... Hernia .....

(a) Palpable Liver .....Spleen .....

Kidneys ..... Tumor .....

(b) Hemorrhoids .....Fistula .....

13. Nervous system:
Indication of nervous or mental disabilities .....

14. Locomotor system: any abnormality .....

15. Urinary system:
Any evidence of hydrocele, varicocele etc. .....

16. Urine examination
(a) Physical appearance .....
(b) Sp. Gr. .....
(c) Albumin .....
(d) Sugar .....
(e) Castro .....
(f) Cells .....

17. Any body deformity:
(a) Knock knees.....
(b) Bow legs.....
(c) Flat feet.....
(d) Carrying angle.....
(e) Any other.....

18. Tattoo .....

19. Any other deformity which declares the candidate unfit .....
.....

20. Reports of screening/X-Ray Examination of chest
.....

21. If there is anything in the health of candidate likely to render him/ her unfit for the efficient discharge of his/her duties in the service for which he/she is a candidate.

Contd.....

22. i) Fit ..... Medical certificate in duplicate enclosed.....

ii) Unfit on account of .....

iii) Temp. unfit on account of .....

Signature .....

Designation of the medical officer
Office seal

Date .....

Annexure IV

Roll No. .....

MEDICAL FITNESS CERTIFICATE FOR APPOINTMENT

Police Department ..... Post.....

Signature of candidate in front of Medical Board :

Candidate's Photo

I do hereby certify that I have examined Mr. /Ms. .....

S/o, D/o Sh. ..... a candidate for employment in Delhi Police department and cannot discover any disease, constitutional infection or bodily infirmity. I do consider him/her fit for employment in Delhi Police.

Signature .....

Designation of the medical officer
Office seal

Date .....

Annexure V

Roll No. .....

MEDICAL CERTIFICATE FOR UNFIT CANDIDATES

Police Department ..... Post.....

Signature of candidate in front of Medical Board :

Candidate's Photo

I do hereby certify that I have examined Mr. /Ms. .....

S/o, D/o Sh. ..... a candidate for employment in Delhi Police department and discovered that he/she has .....

.....

which can interfere in the efficient functioning and performance of police duties. I do consider him/her unfit for employment in Delhi Police.

Signature .....

Designation of the medical officer

Office seal

Date .....

ANNEXURE VI

DME REPORT & CONSENT FORM FOR UNFIT CANDIDATE

Mr. /Ms. ..... Roll No. .....

is hereby informed that he/she has been medically examined for recruitment to the post of ..... on ..... at ..... and found UNFIT due to the reasons mentioned below:

i. .....

ii. .....

iii. .....

iv. .....

2. You are hereby informed that you can apply for Review Medical Examination (RME) by signing on the consent from below. RME will be conducted on ..... for which you are required to report at ..... Hours.

Dated :..... Signature of Medical Officer

Centre :..... Name :

Stamp:

Counter Signature of the Presiding Officer with Seal

Result of Medical Examination received

Name & Signature of the Candidate

FOR USE OF CANDIDATE ONLY

To

The Presiding Officer of Recruitment Board

.....

.....

Subject: APPLICATION FOR REVIEW MEDICAL EXAMINATION

Sir,

I hereby convey my consent for undergoing Review Medical Examination.

Place ..... Signature .....

Date ..... Name .....

Roll No. .....

Signature of Presiding Officer with Seal

ANNEXURE VII

REVIEW MEDICAL EXAMINATION (RME) FORM

REVIEW MEDICAL EXAMINATION HELD AT .....

Name of candidate : .....

Name of post : .....

Roll No. : .....

Father's/Husband Name : .....

Gender : .....

Candidate's Photo

Candidate's Signature

1. Opinion of the medical board on specific disease/disability of unfitness:
   .....
   .....
   .....
2. Brief of Review Medical Examination & Finding thereof:
   .....
   .....
   .....
   .....
3. Final Opinion
   (a) FIT/Unfit
   (b) If unfit, reason thereof .....
   .....
   .....
4. Identification Marks:
   (a) .....
   (b) .....

Place: Date:

Member-I
(Name & Signature with Stamp)

Member-II
(Name & Signature with Stamp)

Presiding Officer
(Name & Signature of Presiding Officer with Seal)

Declaration of candidate

I have received the result of Review Medical Examination.

Signature of the candidate

(NAME IN CAPITAL)

Note: No appeal shall be entertained against the findings of RME