Nursing Assessment	
Name of the Applicant (if not applicant then name of his relative)	
Male/Female	Date of Birth
Occupation of the applicant	
Name of the assessor doctor	
Designation of the doctor	
Medical Details	Description
Give the details of your medical illness, condition and disability	
How does that medical problem affects your daily life	
How do you travel to your work	
Have you undergone any surgery or planning to go for one to improve your medical condition	
Have you experienced any complications after the surgery, if yes then describe it	
Is your hearing, eye sight or any other ability affected by this problem	
Have you ever been cardioverted if yes give the details	
Do you need after care for cardio arrhythmia	
Is there any other medical details which need to be explained for this job or for the insurer to decide your areas of insurance coverage	
Declaration: I hereby declare that all the information presented here are not influenced or withheld by anyone.	
Name of the Physician/Doctor	
Signature of the Physician/Doctor	
Date	