MOH-QA/F/17/67-0

Medical Examination for Work permit Visa

Name of Institute and address with Logo

Please firmly attach a recent passport size photograph of yourself to the form

Stamp of Institute

Part A - Applicant's details

To be filled by the applicant before attending the medical examination. Please write neatly using BLOCK LETTERS.

1. Full Name

2. PP / IDC Number

3. Birth of date

4.Nationality

5. Sex — Male / Female

6. Marital Status — Single / Married / Divorced / Widow

Applicant's medical history

	No	Yes	
1. Have you ever had any serious illness or major surgical operations?			▶
2. Have you ever suffered from Tuberculosis?			▶
3. Have you or has any member of your family suffered from TB , fits or epilepsy?			▶

Applicant's Declaration

I declare the information I have provided on this form is correct and I have answered all understand that if I have given false or misleading information, my application may be refused.

I consent to the facility passing on relevant sensitive information (including about my health) to the doctors who examined me, Ministry of Health , Health Protection Agency (HPA). The reasons for this release of information may include, but are not limited to, investigation and resolution of inconsistencies, complaints , audit recommendations or issues of public health concern.

Applicant's Signature

Part B - Physical Examination - *To be filled by the attending doctor*

Date of Examination (*Date / Month / Year*)

1. Blood pressure — Systolic — Diastolic

2. Ophthalmic findings *(This section to be completed only for relevant occupations)*

	Without corr.	*With corr.*
Right Eye	6/	6/
Left Eye	6/	6/

Color perception — Normal — Partially CB — Totally CB

Clinical Examination

	Normal	Abnormal	
Cardiovascular	☐	☐ ▶	
Respiratory System	☐	☐ ▶	
Digestive Organs	☐	☐ ▶	
Skeleton, Bones & joint	☐	☐ ▶	
Mental Condition	☐	☐ ▶	
Nervous System	☐	☐ ▶	
Genitourinary System	☐	☐ ▶	
Skin, Scar etc	☐	☐ ▶	
Teeth	☐	☐ ▶	
Hearing	☐	☐ ▶	
Gum	☐	☐ ▶	
If Pregnant, Period of Pregnancy	☐	☐ ▶	

For any abnormalities please describe here

Elaborate on positive findings

Doctor's Declaration

I declare that I have examined the applicant and that this is a true correct record of my findings.

I certify that I have confirmed the applicant's identity in terms of papers , photographs and appearance

Full name

Registration Number

Date of Examination (Date / Month / Year)

Doctor's Signature

Part C - X- Ray Results

To be filled by the Radiographer and laboratory Technologist

Hospital / Clinic X- Ray Number ☐ Date ☐☐ Month ☐☐ Year ☐☐☐☐

Radiological findings *(Radiologists opinion where necessary)*

Radiographer's Declaration

I certify that I have confirmed the applicant's identity in terms of papers , photographs and appearance

Full name ☐

Registration Number ☐ Date ☐☐ Month ☐☐ Year ☐☐☐☐

Radiographer's Signature ☐

Part D - Laboratory Examination Results

Blood Analysis

Hb ☐ g/dl

TC ☐ µl

Blood group (**A / B / AB / O**) (*optional) *Positive* ☐ *Negative* ☐

	Positive	*Negative*
VDRL	☐	☐
HbSAg	☐	☐
HIV	☐	☐

Urine Analysis

Albumin ☐ Sugar ☐

Laboratory Technologist's Declaration

I certify that I have confirmed the applicant's identity in terms of papers , photographs and appearance

Full name ☐

Registration Number ☐ Date ☐☐ Month ☐☐ Year ☐☐☐☐

Laboratory Technologist's Signature ☐

Certification by the Doctor

I CERTIFY *that this day examined the above-named, that the results are set forth, and that in my opinion*

a) subject to any special observations listed above, the above-named is in good health and sound consitution and out suffering from any mental or physical defect which would cause inability to work .....
(specify the country/ place)

b) The above-named suffers a mental or physical defect as quoted is NOT in good health.

Full name ☐ Registration Number ☐

Doctor's Signature ☐ Date ☐☐ Month ☐☐ Year ☐☐☐☐