



Full Medical E

DE GUZMAN MARISSA
JOVENAL

All parts in this form are to be completed
completes this form. The foreign worker's T

IC : P7844865A DOB : 29-Sep-1987

Sex : Female

Must be endorsed by the doctor who
ification.

Part I Personal Particulars of Foreign Worker

PID : P175308

Name: _____

Reg. Date : 10-Sep-18 08:23AM HP :

/ Female

Height: 156 cm

Occupation: _____

Date of Birth: _____

Citizenship: _____

Weight: 67 kg

Part II Medical History (To be declared and signed by the foreign worker)

	Yes	No	If yes, give brief details		Yes	No	If yes, give brief details
1 Mental illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>		6 Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2 Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>		7 Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3 Chronic Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>		8 Malaria	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4 Diabetes Mellitus	<input type="checkbox"/>	<input checked="" type="checkbox"/>		9 Operations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5 Hypertension	<input type="checkbox"/>	<input checked="" type="checkbox"/>					

I declare that all the information given above is true and correct. I hereby give my consent for a copy of this medical form after it is completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted in my work permit application.

[Signature]
Signature of Foreign Worker

10 SEP 2018
Date

Part III Please tick if any of the Examinations / Tests is Abnormal and give brief details separately.

Clinical Examinations	Abnormal	Other Tests	Abnormal
1 Cardiovascular System a Blood Pressure Systolic: 124/90 Diastolic: b Heart Disease c ECG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardiac murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1 Chest X-ray - to be taken in Singapore (*For any abnormalities and other findings including no active lung lesion, please state here and attach the chest radiological report to this form.)	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	2 Urine	<input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	a Albumin	<input type="checkbox"/>
4 Abdomen	<input type="checkbox"/>	b Sugar	<input type="checkbox"/>
a Hernia	<input type="checkbox"/>	c Pregnancy	<input type="checkbox"/>
b Enlarged Liver	<input type="checkbox"/>	3 VDRL	<input type="checkbox"/>
c Enlarged Spleen	<input type="checkbox"/>	4 Hearing - unable to hear ordinary conversation at 2m	<input type="checkbox"/>
d Genito-Urinary System	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.)	<input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	a Vision Acuity	<input type="checkbox"/>
6 Locomotor/Neurological	<input type="checkbox"/>	i) Right eye	<input type="checkbox"/>
a Significant limb amputation or deformity	<input type="checkbox"/>	ii) Left eye	<input type="checkbox"/>
b Limb movement and co-ordination	<input type="checkbox"/>	b Colour Vision (for electricians & drivers only)	<input type="checkbox"/>
c Significant spinal deformity	<input type="checkbox"/>	c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>	7 HIV (AIDS)	<input type="checkbox"/>
8 Mental state	<input type="checkbox"/>	Note: HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	

Part IV Certification from the Doctor

I certify that I have examined the above-named foreign worker for the clinical examinations / tests in Part III and found that this person is *Fit / Unfit for employment in the above-stated occupation.

Name of Doctor:
(In BLOCK Letter) Winnie Medical Pte Ltd

Signature of Doctor: _____

Clinic Address: Blk 81 Macpherson Lane #01-35
Singapore 360081

Date: _____

Tel: 6842 7842 Fax: 6743 0954

Telephone Number: _____

*Delete where inapplicable

Doctors to Note:

Please send the completed medical form back to the employer / employment agent promptly, so that they can get the work pass issued.