

Full Medical E

All parts in this form are to be completed  
completes this form. The foreign worker's 1

DE GUZMAN MARISSA  
JOVENAL

IC :P7844865A DOB :29-Sep-1987

Sex :Female

1st be endorsed by the doctor who  
ification.

PID :P175308

Height: 156 cm

Part I Personal Particulars of Foreign Wk

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

/ Female

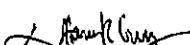
Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

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 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: <u>124/90</u> Diastolic: _____	<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"/>
b Heart Disease	<input type="checkbox"/>		
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)	<input type="checkbox"/>		
d Severe varicose veins	<input type="checkbox"/>	2 Urine a Albumin	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: <u>9%</u> )	<input type="checkbox"/>	b Sugar	<input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	c Pregnancy	<input type="checkbox"/>
4 Abdomen a Hernia	<input type="checkbox"/>	3 VDRL	<input type="checkbox"/>
b Enlarged Liver	<input type="checkbox"/>	4 Hearing – unable to hear ordinary conversation at 2m	<input type="checkbox"/>
c Enlarged Spleen	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.)	<input type="checkbox"/>
d Genito-Urinary System	<input type="checkbox"/>	a Vision Acuity i) Right eye	<input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	i) Left eye	<input type="checkbox"/>
6 Locomotor/Neurological a Significant limb amputation or deformity	<input type="checkbox"/>	b Colour Vision (for electricians & drivers only)	<input type="checkbox"/>
b Limb movement and co-ordination	<input type="checkbox"/>	c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
c Significant spinal deformity	<input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/>	7 HIV (AIDS)	<input type="checkbox"/>
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>	Note: HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	
8 Mental state	<input type="checkbox"/>		

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:

10 SEP 2018

Clinic Address: Blk 81 Macpherson Lane #01-35

Date:

Dr. Chong Kwok Yan

MBBS, DFD

Singapore 360081

Telephone Number:

Tel: 6842 7842 Fax: 6743 0954

S.M.C. No. 003377

\*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.