

Full Medical Examination Form For Foreign Workers

All Parts in this Form are to be completed by a Singapore registered doctor. The foreign worker's Travel Document must be produced to the Examining Doctor for identification.

Part I Personal Particulars of Foreign Worker

Name: _____ Passport No. _____ Sex: *Male / Female Height: _____ cm
 Occupation: _____ Date of Birth: _____ Citizenship: _____ Weight: _____ 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 type="checkbox"/>		6	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
2	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		7	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
3	Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>		8	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
4	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>		9	Operations	<input type="checkbox"/>	<input type="checkbox"/>	
5	Hypertension	<input type="checkbox"/>	<input 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 report after it is completed by the examining 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 _____

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

Part IV Please tick in the box provided

Clinical examinations/tests (*including/excluding ECG) required above are normal except those test results indicated "Abnormal" (if any) in Part III.

Part V Certification from the Doctor (Any amendments must be endorsed by the Doctor who completes this Report)

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

Name of Doctor: _____ Signature of Doctor: _____
 (in BLOCK Letter)
 Clinic Address: _____ Date: _____
 Telephone Number: _____

*Delete where inapplicable

Doctors to Note:

Please give a copy of the completed medical form to the employer/ employment agent if he/she asks for it.