

Kingston Medical (Created by: Admin (HQ)) - Visit Label

NAME: **SI MYINT**  
NRIC/PP No: **M3353195P**  
NATIONALITY: **Myanmar**  
D.O.B: **15/08/1986** SEX: **Female**  
OCCUPATION: **FDW**  
(UNITED CHANNEL SERVICES)  
WOP5

## Registration Form For Foreign Workers

Singapore registered doctor. Any amendments must be endorsed by the doctor who document must be produced to the doctor for identification.

Passport No. \_\_\_\_\_ Sex: \*Male / Female Height: 164 cm  
Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Weight: 59 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.

*fu*

25 MAR 2025

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 a Blood Pressure <u>112/72</u> Systolic: 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.)  Declare Not Pregnant L.M.P: <u>5/3/25</u> Patient's Signature: <u>ku</u>	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	2 Urine a Albumin <u>4 neg</u> b Sugar c Pregnancy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	3 VDRL	<input type="checkbox"/>
4 Abdomen a Hernia b Enlarged Liver c Enlarged Spleen d Genito-Urinary System	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4 Hearing – unable to hear ordinary conversation at 2m	<input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.) a Vision Acuity i) Right eye <u>6/12</u> ii) Left eye b Colour Vision (for electricians & drivers only) c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6 Locomotor/Neurological a Significant limb amputation or deformity b Limb movement and co-ordination c Significant spinal deformity d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>	7 HIV (AIDS) Note: HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	<input type="checkbox"/>
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: **DR POH WEE MIN** MCR:06332J  
(in BLOCK Letter) MBBS

Clinic Address: **KINGSTON MEDICAL CLINIC PTE LTD**

**250 SIMS AVENUE #01-01, SINGAPORE 387513**

Signature of Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

25 MAR 2025

+65 88612806

\*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.



KINGSTON MEDICAL GROUP

Kingston Medical Imaging

250 Sims Ave SPCS Building #01-01 Singapore 387513

## RADIOLOGY REPORT

Name	: SI SI MYINT	Study Date	: 2025-03-25
NRIC No	: M3353195P	Accession No.	: KMA25022101JEX
Age/Sex	: F/38Y7M	Referral Doctor	: DR POH WEE MIN

### CHEST PA

#### CHEST X-RAY

No active lung lesions.  
The heart size is normal

DR MARK TAN  
MBBS (S'pore), FRCR (UK), MMed, FAMS,  
Senior Consultant Radiologist

2025-03-25 16:50:39

*This is a computer generated report. No signature is required  
Please seek medical advice if result is abnormal*

**SI SI MYINT [ Female / 38 years ]**

KINGSTON MEDICAL CLINIC PTE LTD (SIMS AVE)

250 SIMS AVE

#01-01 SPCS BUILDING

SINGAPORE 387513

DR POH WEE MIN

Area : GEY

KING07

**NRIC/FIN/PP** : M3353195P

**MRN/Ref No** : KMGP25019467

**Lab ID** : **25AH5917**
**Date Received** : 25-Mar-2025 18:56

**Report #** : 2030428

**Date Reported** : 25-Mar-2025 20:42

**Test Ordered** : WOP5

**TEST**
**RESULT**
**REF. RANGE**
**WORK PERMIT SCREEN**

Malarial parasites	疟原虫	Negative	(Negative)
HIV Ag/Ab	爱滋病抗原/抗体	Non-reactive	(Non-reactive)
VD (Syphilis TP Ab)	梅毒检验	Non-reactive	(Non-reactive)