

NAME: ZIN MAR MYO
NRIC/PP No: MK198920

Full Medical Examination Form For Foreign Workers

All parts of this form must be completed by a Singapore-registered doctor. Any amendments must be endorsed by the doctor who completes the form and produced to the doctor for identification.

Part I
Nationality: Myanmar
D.O.B: 02/07/2002
SEX: Female
Occupation: FDW
(UNITED CHANNEL SERVICES)
WOP5, MMR

Name: _____ Travel Document No.: _____ Sex: *Male / Female Height: 155 cm
Occupation: _____ Date of Birth: _____ Nationality/Citizenship: _____ Weight: 43 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: Myo Date: 19 SEP 2025

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: 118 Diastolic: 78 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: 17/09/25 Patient's Signature: <u>Myo</u>	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	2 Urine a Albumin b Sugar c Pregnancy	<input type="checkbox"/> <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 > 6/12 ii) Left eye	<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"/>	b Colour Vision (for electricians & drivers only) c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/> <input type="checkbox"/>
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
8 Mental state	<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"/>

Part IV Vaccination given (please provide details, if any)

Type of vaccine	Brand of vaccine	Dose (1 st / 2 nd / 3 rd)
<u>MMR</u>	<u>MMR II</u>	<u>1st</u>

Part V 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 MBBS
Clinic Address: KINGSTON MEDICAL CLINIC PTE LTD
250 SIMS AVE SPCS BUILDING #01-01 SINGAPORE 387513

Signature of Doctor: _____ Date: 19 SEP 2025
Telephone Number: +65 65149008

*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	: ZIN MAR MYO	Study Date	: 2025-09-19
NRIC No	: MK198920	Accession No.	: KMA25069954EQG
Age/Sex	: F/23Y2M	Referral Doctor	: DR POH WEE MIN

CHEST PA

2025-09-19 09:37:40

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

2025-09-19 09:37:40

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

ZIN MAR MYO [Female / 23 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 : MK198920

MRN/Ref No : KMGP25062444

Lab ID : **25AW3488**

Date Received : 19-Sep-2025 11:15

Report # : 2218895

Date Reported : 19-Sep-2025 12:18

Test Ordered : WOP5

TEST	RESULT	REF. RANGE
<u>WORK PERMIT SCREEN</u>		
Malarial parasites	疟原虫	Negative
HIV Ag/Ab	爱滋病抗原/抗体	Non-reactive
VD (Syphilis TP Ab)	梅毒检验	Non-reactive