

Work Pass Division 18 Havelock Road Singapore 059764 www.mom.gov.sg



## Full Medical Examination Form For Foreign Workers

| Part II Personal Particulars of Foreign Worker  Part II Medical History (To be declared and si PID : P148762    Mental Illness   | I dii Medicai Exe  |  | or roleight workers              | <u> </u>                     |              |
|--|--|--|----------------------------------|------------------------------|--------------|
| Name:   IC AT347043 DOB :12-Apr-1991   remaile   Height:   Meight   Meight  | All parts in this form are to be completed by completes this form. The foreign worker's Trav $\begin{tabular}{ll} Winnie Iblie Blk 81 M \\ \hline \end{tabular}$   | vledical Centre<br>dacpherson Lane #01 | 35 Singapore 360081              |                              | ctor who     |
| Part II Medical History (To be declared and si PID_P148762    Mental illness   | Part I Personal Particulars of Foreign Worker HAN  | IIYAH                                  |                                  |                              |              |
| Part II Medical History (To be declared and si PID -P148762    Mental Illness  | N AT   | 247040 000                             |                                  |                              | 4L           |
| Part II Medical History (To be declared and si PID -P148762    Medical History (To be declared and si PID -P148762   Reg. Date :11-Feb-17 09:00AM HP: No. If yes, give brief details   Pipe   P | Name:dom 1 oh7 warrar  | IC :AT347043 DOB :12-Apr-1991          |                                  | emale Height:/               | cm           |
| Mental illness   | Occupation: William Sex :F   | emale                                  |                                  | Weight:                      | kg           |
| Mental iliness   Test   | Part II Medical History (To be declared and si PID :P  | 148762                                 |                                  |                              |              |
| 1 Mental illness   | Vos No If you  | Date :11-Feb-17                        | 09:00AM HP:                      | No. If was give brief data   | ile          |
| I declare that all the information given above is true and correct. I hereby give my consent for a copy of this medical form afte completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted work permit application.  |  |  | 10 1000.00                       | il yes, give blief deta      | ilis         |
| I declare that all the information given above is true and correct. I hereby give my consent for a copy of this medical form afte completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted work permit application.  | 2 Epilepsy $\square$   |  | 7 Heart Disease                  |                              |              |
| I declare that all the information given above is true and correct. I hereby give my consent for a copy of this medical form afte completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted work permit application.  | 3 Chronic Asthma   |  | 8 Malaria                        |                              |              |
| I declare that all the information given above is true and correct.   I hereby give my consent for a copy of this medical form afte completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted work permit application.    I   | 4 Diabetes Mellitus  |  | 9 Operations                     |                              |              |
| completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted work permit application.    The proof of the pr | - Hypertenoism   |  |                                  |                              |              |
| Part III   Please tick if any of the Examinations / Tests is Abnormal and give brief details separately.   | completed by the doctor to be released to the Ministry work permit application.  |  |                                  | e employment agent who ass   | sisted in my |
| Part III Please tick if any of the Examinations / Tests is Abnormal and give brief details separately.    Clinical Examinations  |  |  | Date                             |                              |              |
| Clinical Examinations  |  |  |                                  |                              |              |
| 1 Cardiovascular System a Blood Pressure Systolic: Diastolic: Diastolic: Diastolic: Diastolic: Diastolic: Diastolic: 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 cardic murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins  2 Anaemia (if clinically anaemic, do HB:  | Part III Please tick if any of the Examinations / Tests  | is Abnormal and                        | give brief details separately.   |                              |              |
| a Blood Pressure Systolic: Diastolic: Diastolic: Diesart Disease CECG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardic murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins 2 Anaemia (if clinically anaemic, do HB: g%) 3 Respiratory System 4 Abdomen 4 Hernia 5 Enlarged Spleen 6 Genito-Urinary System 5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc) 6 Locomotor/Neurological a Significant limb amputation or deformity d Other significant abnormalities (in relation to the Work required to be performed) 7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  | Clinical Examinations  | Abnormal                               | Other Tests                      |                              | Abnormal     |
| 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 cardic murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins  2 Anaemia (if clinically anaemic, do HB:   |  |  |                                  |                              |              |
| Diastolic: b Heart Disease CEG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardic murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins 2 Anaemia (if clinically anaemic, do HB: g%)   | The state of the s |  |                                  |                              |              |
| b Heart Disease (  | \ \frac{1}{2}  |  |                                  |                              |              |
| C ECG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardic murmurs or symptoms suggestive of Myocardial ischaemia)   2 Urine   3 Albumin   2 Anaemia (if clinically anaemic, do HB:  | rn la L  |  | radiological report to this      | 101111.)                     |              |
| indicated, e.g. persons with cardic murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins  2 Anaemia (if clinically anaemic, do HB:  |  |  |                                  |                              | 15/4         |
| symptoms suggestive of Myocardial ischaemia) d Severe varicose veins 2 Anaemia (if clinically anaemic, do HB:  |  | is                                     |                                  |                              | 31 1         |
| d Severe varicose veins  2 Anaemia (if clinically anaemic, do HB:  |  |  | O. Heima                         |                              |              |
| 2 Anaemia (if clinically anaemic, do HB:   |  |  |                                  |                              |              |
| C Pregnancy      |  |  |                                  |                              |              |
| a Hernia b Enlarged Liver c Enlarged Spleen d Genito-Urinary System 5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc) 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) 7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  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 / Urifit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  4 Hearing — unable to hear ordinary conversation at 2m   |  |  |                                  |                              |              |
| b Enlarged Liver c Enlarged Spleen d Genito-Urinary System  5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)  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)  7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  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)  Clinic Address:  5 Vision (should be at least 6/12 in both eyes with or without glasses.) a Vision Acuity i) Right eye ii) Left eye  C Colour Vision (for electricians & drivers only) c Any organic eye disease, e.g. Trachoma  6 Blood film for Malaria 7 HIV (AIDS) 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)  Clinic Address:  Telephone Number:  |  |  |                                  |                              |              |
| c Enlarged Spleen d Genito-Urinary System Skin-Chronic Disease (e.g. leprosy, widespread eczama, psoriasis, etc) b 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) T Endocrine disorders, e.g. thyrotoxicosis Mental state  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 / Urifit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Or without glasses.) a Vision Acuity i) Right eye ii) Left eye b Colour Vision (for electricians & drivers only) c Any organic eye disease, e.g. Trachoma  6 Blood film for Malaria 7 HIV (AIDS) 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 / Urifit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Telephone Number:   |  |  |                                  |                              |              |
| d Genito-Urinary System  5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)  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) 7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  Part IV Certification from the Doctor  I certify that I have examined the above-named foreign worker for the clinical examinations / tests in Part IV and found that this person is * Fit / Urifit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Telephone Number:  a Vision Acuity i) Right eye ii) Left eye b Colour Vision (for electricians & drivers only) c Any organic eye disease, e.g. Trachoma  6 Blood film for Malaria 7 HIV (AIDS) Note: HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.  Signature of Doctor:  Signature of Doctor:  Date: Telephone Number:   |  |  |                                  | 6/12 in both eyes with       |              |
| Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)   i) Right eye   ii) Left eye   czema, psoriasis, etc)   6 Locomotor/Neurological   a Significant limb amputation or deformity   c Any organic eye disease, e.g. Trachoma   c Significant spinal deformity   d Other significant abnormalities (in relation to the Work required to be performed)   T Endocrine disorders, e.g. thyrotoxicosis   done at laboratories approved by the Ministry of Health.   Name of Doctor: (in BLOCK Letter)   Clinic Address:   Date:   Wirnie Medical Pte Ltd   Telephone Number:   Date:   Telephone Number:   Calling the first province of the clinical examination of the province of the clinical examination of the content of the province of the clinical examination of the clinical examinat   |  |  |                                  |                              | ln           |
| eczema, psoriasis, etc)  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) 7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  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)  Clinic Address:    ii) Left eye   b Colour Vision (for electricians & drivers only)   c Any organic eye disease, e.g. Trachoma   7 HIV (AIDS)   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:  |  |  |                                  |                              |              |
| 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) 7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  Part IV Certification from the Doctor I certify that I have examined the above-named foreign worker for the clinical examinations / tests in Part IV and found that this person is * Fit / Unfit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Winnie Medical Pte Ltd  C Any organic eye disease, e.g. Trachoma  6 Blood film for Malaria  7 HIV (AIDS) Note:  HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.  Signature of Doctor:  (in BLOCK Letter)  Clinic Address:  Date: Telephone Number:  | eczema, psoriasis, etc)  |  | ii) Left eye                     |                              |              |
| b Limb movement and co-ordination c Significant spinal deformity d Other significant abnormalities (in relation to the Work required to be performed) 7 Endocrine disorders, e.g. thyrotoxicosis 8 Mental state  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)  Clinic Address:  Date:  Telephone Number:  |  |  |                                  |                              |              |
| c Significant spinal deformity d Other significant abnormalities (in relation to the Work required to be performed)  7 Endocrine disorders, e.g. thyrotoxicosis Note: HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry 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) Clinic Address:  Telephone Number:   |  |  |                                  | e.g. Tracnoma                |              |
| d Other significant abnormalities (in relation to the Work required to be performed)  7 Endocrine disorders, e.g. thyrotoxicosis  8 Mental state  Part IV Certification from the Doctor  I certify that I have examined the above-named foreign worker for the clinical examinations / tests in Part IV and found that this person is * Fit / Unfit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Date:  Telephone Number:   |  |  |                                  | Λ                            |              |
| 7 Endocrine disorders, e.g. thyrotoxicosis 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 IV and found that this person is * Fit / Unfit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Date:  Telephone Number:  |  |  | ,                                |                              | -            |
| 8 Mental state   | A CONTROL OF THE CONT |  |                                  |                              |              |
| 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)  Clinic Address:  Date:  Telephone Number:  |  |  | -                                | proved/by/the Ministry       |              |
| 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)  Clinic Address:  Date:  Telephone Number:   | 8 Mental state   |  | of Health.                       |                              |              |
| 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 / Urfit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Date:  Telephone Number:   | Part IV Certification from the Doctor  |  |                                  |                              |              |
| person is * Fit / Unfit for employment in the above-stated occupation.  Name of Doctor: (in BLOCK Letter)  Clinic Address:  Winnie Medical Pte Ltd  Telephone Number:  |  |  |                                  |                              |              |
| Name of Doctor: (in BLOCK Letter)  Clinic Address:  Signature of Doctor:  Date:  Telephone Number:   |  |  | clinical examinations / tests in | Part III and found that this |              |
| (in BLOCK Letter)  Clinic Address:  Date:  Telephone Number:   | person is Tit 7 diffit for employment in the above-sta   | ted occupation.                        |                                  |                              |              |
| Clinic Address:  Date:  Telephone Number:  |  |  | Cianatura of Dag                 |                              |              |
| Wirmie Medical Pte Ltd Telephone Number:   | **************************************   |  |                                  | Stor.                        |              |
|  |  | Design -                               | Date:                            |                              |              |
|  | — Winnie Medical Pt  | te Ltd                                 | Telephone Numb                   | oer:                         |              |
| * Delete where inapplicable k 81 Macpherson Lane #U1-35 MCR No. 01947Z   | * Delete where inapplicable 81 Macpherson Lane   |  | Or Leong Chee Lum                | 13 FEB 2017                  |              |
| Doctors to Note: Singapore 360081  | Singapore 360081   |  | 1017 1401 013 17 18              |                              |              |