

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

Winnie Medical Centre
Blk 81 Macpherson Lane #01-35 Singapore 360081



AYE MYAT MON

Full Med

IC:MD810226 DOB:19-Apr-1995

Sex:Female

PID:P182027

Reg. Date:08-Jan-19 02:40PM HP:

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nents must be endorsed by the doctor who
for identification.

All parts in this form are to be cc
completes this form. The foreign w

Part I Personal Particulars of Fo

Name: _____ Passport No. _____ Sex: *Male / Female Height: 156 cm
Occupation: _____ Date of Birth: _____ Citizenship: _____ Weight: 57 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.

X AYE MYAT MON Date 08 JAN 2019
Signature of Foreign Worker

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>113</u> Diastolic: <u>78</u> 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.) 2 Urine a Albumin b Sugar c Pregnancy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%) 3 Respiratory System 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"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3 VDRL 4 Hearing - unable to hear ordinary conversation at 2m 5 Vision (should be at least 6/12 in both eyes with 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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <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: Winnie Medical Pte Ltd Signature of Doctor: _____
(in BLOCK Letter)
Clinic Address: Blk 81 Macpherson Lane #01-35 Date: _____
Singapore 360081 Telephone Number: Dr Leong Chee Lum
Tel: 6842 7842 Fax: 6743 0954 MCR No. 019472
09 JAN 2019

*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.