

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



Fui

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

n Workers

All parts in this form are to be completed by the doctor who completes this form. The foreign worker's name must be written in BLOCK LETTERS.

All amendments must be endorsed by the doctor who completes this form for identification.

## Part I Personal Particulars

Name: SUDARWATI IC :B7363215 DOB :08-Sep-1994  
Sex :Female  
Occupation: \_\_\_\_\_  
PID :P161918

Sex: \* Male / Female Height: 146 cm  
Citizenship: \_\_\_\_\_ Weight: 47 kg

## Part II Medical History (To be completed by the doctor)

Reg. Date :28-Nov-17 04:44PM HP : \_\_\_\_\_

	Yes	No	If yes, give brief details
1 Mental illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2 Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3 Chronic Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4 Diabetes Mellitus	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5 Hypertension	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6 Tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
7 Heart Disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
8 Malaria	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
9 Operations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	CS 2014

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]*

28 NOV 2017

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 (* For any abnormalities and other findings including no active lung lesion, please state here and attach the chest radiological report to this form.)	<input type="checkbox"/>
a Blood Pressure	<input type="checkbox"/>		
Systolic: <u>130/70</u>			
Diastolic: <u>70</u>			
b Heart Disease	<input type="checkbox"/>	2 Urine	<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"/>	a Albumin	<input type="checkbox"/>
d Severe varicose veins	<input type="checkbox"/>	b Sugar	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	c Pregnancy	<input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	3 VDRL	<input type="checkbox"/>
4 Abdomen		4 Hearing - unable to hear ordinary conversation at 2m	<input type="checkbox"/>
a Hernia	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.)	<input type="checkbox"/>
b Enlarged Liver	<input type="checkbox"/>	a Vision Acuity	<input type="checkbox"/>
c Enlarged Spleen	<input type="checkbox"/>	i) Right eye	<input type="checkbox"/>
d Genito-Urinary System	<input type="checkbox"/>	ii) Left eye	<input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	b Colour Vision (for electricians & drivers only)	<input type="checkbox"/>
6 Locomotor/Neurological		c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
a Significant limb amputation or deformity	<input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
b Limb movement and co-ordination	<input type="checkbox"/>	7 HIV (AIDS)	<input type="checkbox"/>
c Significant spinal deformity	<input type="checkbox"/>	Note:	
d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/>	HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	
7 Endocrine disorders, e.g. thyrotoxicosis	<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: Winnie Medical Pte Ltd  
(in BLOCK Letter) Blk 81 Macpherson Lane #01-35  
Clinic Address: Singapore 360081  
Tel: 6842 7842 Fax: 6743 0954

Signature of Doctor: *[Signature]*Date: 29 NOV 2017Telephone Number: 6743 0954

\* 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.