

**THAT HTAR SU HLAING**

IC :MB924011 DOB :10-Oct-1990

Sex :Female

PID :P182929

**Full Medical**

All parts in this form are to be completed by the foreign worker.

Reg. Date :23-Jan-19 03:04PM HP :

Must be endorsed by the doctor who identifies the foreign worker.

**Part I Personal Particulars of Foreign Worker**

Name: \_\_\_\_\_ Passport No. \_\_\_\_\_ Sex: \*Male / Female Height: 154 cm  
Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Weight: 69 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 checked="" type="checkbox"/>	<input 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.

*That Htar Su Hlaing*

**23 JAN 2019**

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 Systolic: <u>139</u> Diastolic: <u>89</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.)	<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"/>
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 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"/>
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)	<input type="checkbox"/>
8 Mental state	<input type="checkbox"/>	<b>Note:</b> 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)

**Winnie Medical Pte Ltd**  
**Blk 81 Macpherson Lane #01-35**

Signature of Doctor:

Clinic Address:

**Singapore 360081**  
**Tel: 6842 7842 Fax: 6743 0954**

Date:

**Dr Leong Chee Lum**  
**MCR No. 019472**

Telephone Number:

\*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.

**24 JAN 2019**