

### Full Medical

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

FADERO MA THERESA

**All parts in this form are to be completed. The foreign worker's**

IC :EC6226490 DOB :29-Aug-1976

must be endorsed by the doctor who  
identification.

### Part I Personal Particulars of Foreign V

**Sex :Female**

Name: \_\_\_\_\_

PID :P168631

le / Female

Height: 194 cm

Occupation:

Reg. Date :12-May-18 08:32AM HP :

Weight: 36 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<i>Hypertension a malade</i>				

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.

~~CONFIDENTIAL~~

FADERW, MA.THERESA

12 MAY 2018

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: 170 Diastolic: 90 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 checked="" 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 3 VDRL	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	4 Hearing – unable to hear ordinary conversation at 2m	<input type="checkbox"/>
3 Respiratory System	<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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <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"/>	b Colour Vision (for electricians & drivers only) c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/> <input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	6 Blood film for Malaria	<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"/>	7 HIV (AIDS) <b>Note:</b> HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	<input type="checkbox"/>
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:  
(in BLOCK Letter) Winnie Medical Pte Ltd

Signature of Doctor:

Clinic Address: Blk 81 Macpherson Lane #01-35

Date:

Singapore 360081

Telephone Number:

Tel: 6842 7842 Fax: 6743 0954

\*Delete where inapplicable

19 MAY 2018

**Doctors to Note:**

**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.

WPCM 015

The information is updated on 27 Mar 2018