

## Full Medical Examination Form

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

All parts in this form are to be completed by the foreign worker. The foreign worker must be endorsed by the doctor who or identification.

### Part I Personal Particulars of Foreign Worker

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

Occupation: \_\_\_\_\_

**REYES MARIFE BAYAWA**

IC : P8485365A DOB : 31-Jan-1992

Sex : Female

PID : P182412

Reg. Date : 22-Feb-19 10:54AM HP :

### Markers

Markers must be endorsed by the doctor who or identification.

\*Male / Female

Height: 152 cm

Marital Status: \_\_\_\_\_

Weight: 63 kg

### Part II Medical History (To be declared by the foreign worker)

	Yes	No		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.

Signature of Foreign Worker

Date

**22 FEB 2019**

### 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:			
Diastolic:			
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:  
(in BLOCK Letter)

**Winnie Medical Pte Ltd**

Signature of Doctor:

**Dr. Andrew W. K. Chee**

Clinic Address:

**Blk 81 Macpherson Lane #01-35**

Date:

**M.B., B.S. (S'pore) (1979)**

**Singapore 360081**

Telephone Number:

**Family Physician**

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

**MCR : 02587/I**

\*Delete where inapplicable

**23 FEB 2019**

### 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.

# Winnie X-Ray Centre

Blk 81, Macpherson Lane #01-35 Singapore 360081 Tel: 6842 7842 Fax: 6743 0954

---

Patient Name : REYES MARIFE BAYAWA

Age/Sex : 27/F

Case No : W1218610

Referring Doctor : Dr. Chong Kwok Yan

NRIC NO : P8485365A

Date : 22/02/2019

---

**Examination** CHEST X-RAY - SCREENING X

## **CHEST**

No active lung disease.

Normal cardiac and mediastinal outlines.

## **COMMENTS**

Normal findings.



## PATHOLOGY AND CLINICAL LABORATORY PTE. LTD.

45 Kallang Pudding Road #05-01/04 Alpha Building Singapore 349317  
Tel: (65) 67429011 (8 Lines) Fax: (65) 67429226 E-mail: pathlabs@singnet.com.sg  
RCB No. 197200753W

Client ID: 33305

WINNIE MEDICAL CENTRE  
BLK 81 MACPHERSON LANE  
#01-35  
SINGAPORE  
36008-1

Patient: REYES MARIFE BAYAWA

IC/PP...: P8485365A  
Age....: 27 Sex: F  
Ref. No: P182412

Request Date: 22/02/2019  
Report Date : 23/02/2019  
Lab Number...: 11342437  
Page Number : 1

\*\* FINAL REPORT \*\*

Test Name	Results	Units	Reference Range
<u>WK6 Profile</u>	.....		
VDRL	Negative		
HIV I & II Ab	Negative		
Malaria Parasite (MP)	Negative		
	梅毒检验		
	爱滋病抗体		

This is a computer generated report. No signature is required.

Dr. S H Leong, Medical Director





# Winnie X-Ray Centre

Blk 81, Macpherson Lane #01-35 Singapore 360081 Tel: 6842 7842 Fax: 6743 0954

---

Patient Name : **NAN EI MON**

Age/Sex : **23/F**

Case No : **W1218817**

Referring Doctor : **Dr. Chong Kwok Yan**

NRIC NO : **MD979095**

Date : **22/02/2019**

---

**Examination** CHEST X-RAY - SCREENING X

## **CHEST**

No active lung disease is seen.

Normal cardiac and mediastinal outlines.

Mild thoracic scoliosis is noted.

## **COMMENT**

**No active lung disease is seen.**



## **PATHOLOGY AND CLINICAL LABORATORY PTE. LTD.**

45 Kallang Pudding Road #05-01/04 Alpha Building Singapore 349317  
Tel: (65) 67429011 (8 Lines) Fax: (65) 67429226 E-mail: pathlabs@singnet.com.sg  
RCB No. 197200753W

Client ID: 33305

Patient: NAN EI MON

WINNIE MEDICAL CENTRE  
BLK 81 MACPHERSON LANE  
#01-35  
SINGAPORE  
36008-1

IC/PP...: MD979095  
Age....: 23 Sex: F  
Ref. No: P184464

Request Date: 22/02/2019  
Report Date : 23/02/2019  
Lab Number...: 11342647  
Page Number : 1

**\*\* FINAL REPORT \*\***

Test Name	Results	Units	Reference Range
<b>WK6 Profile</b>			
VDRL	梅毒检验	.....	Negative
HIV I & II Ab	爱滋病抗体		Negative
Malaria Parasite (MP)			Negative

This is a computer generated report. No signature is required.

**Dr. S H Leong**, Medical Director



### Full Medi

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

### rkers

All parts in this form are to be completed by the foreign worker. The foreign worker must be endorsed by the doctor who or identification.

**HOU DEIH MAN**

#### Part I Personal Particulars of Foreign Worker

IC : MB722834 DOB : 20-Jun-1993

Sex : Female

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

PID : P184473

\*Male / Female

Height: 143 cm

Occupation: \_\_\_\_\_

Reg. Date : 22-Feb-19 03:17PM HP :

Weight: 38 kg

#### Part II Medical History (To be declared 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.

22 FEB 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		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: 119			
Diastolic: 80			
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:  
(in BLOCK Letter)

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

Signature of Doctor: Dr. Andrew W. K. Chee

Clinic Address:

Singapore 360081  
Tel: 6842 7842 Fax: 6743 0954

Date:

M.B., B.S. (Singapore) (1979)

Telephone Number:

Family Physician

MCR : 02587/I

\*Delete where inapplicable

23 FEB 2019

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.

# Winnie X-Ray Centre

Blk 81, Macpherson Lane #01-35 Singapore 360081 Tel: 6842 7842 Fax: 6743 0954

---

Patient Name : HOU DEIH MAN

Age/Sex : 25/F

Case No : W1218823

Referring Doctor : Dr. Chong Kwok Yan

NRIC NO : MB722834

Date : 22/02/2019

---

**Examination** CHEST X-RAY - SCREENING X

## **CHEST**

No active lung disease.

Normal cardiac and mediastinal outlines.

## **COMMENTS**

**Normal findings.**





## PATHOLOGY AND CLINICAL LABORATORY PTE. LTD.

45 Kallang Pudding Road #05-01/04 Alpha Building Singapore 349317  
Tel: (65) 67429011 (8 Lines) Fax: (65) 67429226 E-mail: pathlabs@singnet.com.sg  
RCB No. 197200753W

Client ID: 33305  
WINNIE MEDICAL CENTRE  
BLK 81 MACPHERSON LANE  
#01-35  
SINGAPORE  
36008-1

Patient: HOU DEIH MAN

IC/PP...: MB722834  
Age....: 25 Sex: F  
Ref. No: P184473

Request Date: 22/02/2019  
Report Date : 23/02/2019  
Lab Number...: 11342643  
Page Number : 1

\*\* FINAL REPORT \*\*

Test Name	Results	Units	Reference Range
<b>WK6 Profile</b>			
VDRL	梅毒检验	.....	Negative
HIV I & II Ab	爱滋病抗体		Negative
Malaria Parasite (MP)			Negative

This is a computer generated report. No signature is required.

Dr. S H Leong, Medical Director

**Full**

**CHAW CHAW EI**

**Workers**

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

IC : MD940322 DOB : 07-Apr-1991

Sex : Female

PID : P184463

Reg. Date : 22-Feb-19 03:10PM HP :

Endorsements must be endorsed by the doctor who is the doctor for identification.

**Part I Personal Particulars**

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

Sex: ☒ Male / ☐ Female

Height: 150 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.

Signature of Foreign Worker

Date

**22 FEB 2019**

**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			
Systolic: <u>140/80</u>	<input type="checkbox"/>		
Diastolic:			
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"/>	<b>Note:</b>	
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

Signature of Doctor: \_\_\_\_\_

Clinic Address: Singapore 360081

Date: \_\_\_\_\_

Tel: 6842 7842 Fax: 6743 0954

Telephone Number: \_\_\_\_\_

Dr. Andrew W. K. Chee  
M.B., B.S. (S'pore) (1979)  
Family Physician  
MCR : 02587/I

\*Delete where inapplicable

**23 FEB 2019**

**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.

# Winnie X-Ray Centre

Blk 81, Macpherson Lane #01-35 Singapore 360081 Tel: 6842 7842 Fax: 6743 0954

---

Patient Name : **CHAW CHAW EI**

Age/Sex : **27/F**

Case No : **W1218813**

Referring Doctor : **Dr. Chong Kwok Yan**

NRIC NO : **MD940322**

Date : **22/02/2019**

---

**Examination** CHEST X-RAY - SCREENING X

## **CHEST**

No active lung disease.

Normal cardiac and mediastinal outlines.

## **COMMENTS**

**Normal findings.**



## **PATHOLOGY AND CLINICAL LABORATORY PTE. LTD.**

45 Kallang Pudding Road #05-01/04 Alpha Building Singapore 349317  
Tel: (65) 67429011 (8 Lines) Fax: (65) 67429226 E-mail: pathlabs@singnet.com.sg  
RCB No. 197200753W

Client ID: 33305

Patient: CHAW CHAW EI

WINNIE MEDICAL CENTRE  
BLK 81 MACPHERSON LANE  
#01-35  
SINGAPORE  
36008-1

IC/PP...: MD940322  
Age....: 27 Sex: F  
Ref. No: P184463

Request Date: 22/02/2019  
Report Date : 23/02/2019  
Lab Number...: 11342646  
Page Number : 1

**\*\* FINAL REPORT \*\***

Test Name	Results	Units	Reference Range
<b>WK6 Profile</b>			
VDRL	梅毒检验	.....	Negative
HIV I & II Ab	爱滋病抗体		Negative
Malaria Parasite (MP)			Negative

This is a computer generated report. No signature is required.

**Dr. S H Leong, Medical Director**



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

**AYE SEIN**

IC : MB735617 DOB : 14-Jan-1987

Sex : Female

PID : P143259



**MINISTRY OF  
MANPOWER**

**Full Me** Reg. Date : 22-Feb-19 03:10PM HP :

**Vorkers**

All parts in this form are to be completed by a Singapore registered doctor. Any amendments must be endorsed by the doctor who completes this form. The foreign worker's Travel Document must be produced to the doctor for identification.

**Part I Personal Particulars of Foreign Worker**

Name: \_\_\_\_\_ Passport No. \_\_\_\_\_ Sex: \*Male / Female Height: 147 cm  
Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Weight: 49 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.

*[Signature]*

**22 FEB 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>138/80</u> 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 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"/>
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) <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"/>
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: Dr. Andrew W. K. Chee  
Date: M.B., B.S. (S'pore) (1979)  
Telephone Number: Family Physician  
MCR : 02587/I

\*Delete where inapplicable

**23 FEB 2019**

**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.

# Winnie X-Ray Centre

Blk 81, Macpherson Lane #01-35 Singapore 360081 Tel: 6842 7842 Fax: 6743 0954

---

Patient Name : **AYE SEIN**

Age/Sex : **32/F**

Case No : **W1218811**

Referring Doctor : **Dr. Chong Kwok Yan**

NRIC NO : **MB735617**

Date : **22/02/2019**

---

**Examination** CHEST X-RAY - SCREENING X

**CHEST**

No active lung disease.

Normal cardiac and mediastinal outlines.

**COMMENTS**

Normal findings.



## PATHOLOGY AND CLINICAL LABORATORY PTE. LTD.

45 Kallang Pudding Road #05-01/04 Alpha Building Singapore 349317  
Tel: (65) 67429011 (8 Lines) Fax: (65) 67429226 E-mail: pathlabs@singnet.com.sg  
RCB No. 197200753W

Client ID: 33305

Patient: AYE SEIN

WINNIE MEDICAL CENTRE  
BLK 81 MACPHERSON LANE  
#01-35  
SINGAPORE  
36008-1

IC/PP...: MB735617  
Age....: 32 Sex: F  
Ref. No: P143259

Request Date: 22/02/2019  
Report Date : 23/02/2019  
Lab Number...: 11342648  
Page Number : 1

\*\* FINAL REPORT \*\*

Test Name	Results	Units	Reference Range
<b>WK6 Profile</b>	.....		
VDRL	梅毒检验	Negative	
HIV I & II Ab	爱滋病抗体	Negative	
Malaria Parasite (MP)		Negative	

This is a computer generated report. No signature is required.

Dr. S H Leong, Medical Director