



RIYANI

IC AT794510 DOB 02-Mar-1991  
Sex: Female

ers

Full Medical

All parts in this form are to be completed by the foreign worker. The foreign worker must be endorsed by the doctor who identifies him/her.

PID: P184289

Reg Date 21-Feb-19 08 25AM HP

Part I Personal Particulars of Foreigner...

Name: \_\_\_\_\_ Passport No.: \_\_\_\_\_ Sex: Male / Female Height: 149 cm  
Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Weight: 55 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]*

21 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: 120 / 80 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.) 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) Note: 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  
Clinic Address: Blk 81 Macpherson Lane #01-35  
Singapore 360081  
Tel: 6842-7842 Fax: 6743-0954

Signature of Doctor

Date

Telephone Number

*[Signature]*

Dr Foo Jong Hiang  
MCR: 088962

\*Delete where inapplicable

21 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