MEDICAL REPORT

PHOTO	NAME:			
	NATIONALITY:	SEX:	AGE:	MARITAL STATUS:
	PASSPORT NO:	ISSUE PLACE:		ISSUE DATE:
	POSITION APPLIED FOR:			

DEAR SIR / MADAM
PLEASE, ARRANGE TO EXAMINE THE ABOVE MENTIONED CANDIDATE AS TO HIS/HER FITNESS FOR THE ABOVE MENTIONED POSITION.

DATE ____/ ____ / _____ RECRUITMENT ATTACHE/OR DOCTOR: _____

HISTORY OF ANY SIGNIFICANT PAST ILLNESS INCLUDING:

- PSYCHIATRIC AND NEUROLOGICAL DISORDERS (EPILEPSY, DEPRESSION…)
- ALLERGY

MEDICAL EXAMINATION					LABORATORY INVESTIGATION		
TYPE OF MEDICAL EXAMINATION			NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL	TYPE OF LABORATORY INVESTIGATION	NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL
VISION		R. EYE			(URINE)		
		L. EYE			- SUGAR		
EYE					- ALBUMIN		
	OTHER	R. EYE			- BILHARZIASIS		
		L. EYE			- OTHER		
EAR		R. EAR			(STOOL)		
		L. EAR			- HELMINTHES		
CHEST X - RAY					- SALMONELLA/SHIGELLA		
PULMONARY TUBERCULOSIS					- V.CHOLERA		
(SYSTEMIC EXAMINATION)					- OTHER		
BLOOD PRESSURE					(BLOOD)		
HEART					- HEMOGLOBIN		
LUNGS					- MALARIA FILM		
ABDOMEN					- OTHERS		
(OTHERS)					(SEROLOGY)		
*HERNIA					- HIV TEST		
*VARICOSE VEINS							
EXTREMITIES					-F.B.S.		
SKIN					- HBSAG/ANTI HCV		
(VENEREAL DISEASES					-L.F.T.		
- CLINICAL					- CREATININE		
- LAB					- UREA		
VDRL							
TPHA					PREGNANCY TEST		

CONFIRM IF THE APPLICATION HAS ONE OF THE FOLLOWING:	NO	YES
COMMUNICABLE DISEASES		
MENTAL DISORDER		
MENTAL RETARDATION		
PHYSICAL DISORDERS		
HANDICAP		
PARALYSIS		
BLINDNESS		
HEARING DISORDER		
SPEECH DISORDER		

MENTIONED ABOVE IS THE MEDICAL REPORT FOR MR / MRS / MISS _____ , WHO IS
[ ] FIT [ ] UNFIT FOR THE ABOVE MENTIONED JOB.

- TO BE FIT, ALL MEDICAL EXAMINATIONS AND LABORATORY INVESTIGATIONS MUST BE WITHIN NORMAL LIMITS. IN THE EVENT OF AN ABNORMAL/POSITIVE RESULT, A TYPEWRITTEN LETTER SIGNED BY THE PHYSICIAN STATING THE CONDITION AND ANY TREATMENT IMPLEMENTED. THIS LETTER SHOULD ALSO INDICATE WHETHER THIS CONDITION OR TREATMENT WILL HAVE ANY EFFECT ON THE APPLICANT'S WORK.

PHYSICIAN NAME: _____ SIGNATURE: _____
LICENSE NUMBER: _____ STAMP:

THIS FORM MUST BE ATTESTED BY ONE OF THE TWO FOLLOWING AUTHORITIES:

THIS IS TO CERTIFY THAT DR. _____ LICENSE NUMBER: _____ ,
IS CURRENTLY LICENSED TO PRACTICE MEDICINE.
(1)

AUTHORIZED SIGNATURE : | STAMP OR SEAL OF THE STATE AUTHORITY (COLLEGE OF PHYSICIANS)

DEPARTMENT OF HEALTH
(2)