MEDICAL REPORT

REPORT OF ANY SIGNIFICANT ILL OR DISCLOSURE	
- PHYSICAL AND PSYCHOLOGICAL DISORDERS (INCLUDE DETAILS)	
- ALCOHOL	

MEDICAL EXAMINATION					LABORATORY INVESTIGATION		
TYPE OF MEDICAL EXAMINATION			MEANING NORMAL	PARTIAL ABNORMAL	TYPE OF LABORATORY INVESTIGATION	MEANING NORMAL	PARTIAL ABNORMAL
VISION		R EYE			URINE		
		L EYE			- SUGAR		
EYE					- ALBUMIN		
	OTHER	R EYE			- BLOOD SUGAR		
		L EYE			- OTHER		
EAR		R EAR			SPUTUM		
		L EAR			- TUBERCULOSIS		
CHEST X-RAY					- CARCINOMA CARCINOMA		
PULMONARY TUBERCULOSIS					- CARCINOMA		
CARDIOVASCULAR SYSTEM					- OTHER		
BLOOD PRESSURE					BLOOD		
HEART					- HEPATITIS		
LUNGS					- HEPATITIS B		
ABDOMEN					- OTHER		
HERNIA					HEPATITIS		
HERNIA					- HIV TEST		
VERTEBRAL COLUMN							
EXTREMITIES					- E.S.R.		
SKIN					- HEMOGLOBIN		
GENERAL REMARKS					- C.T.T.		
- CONTROL					- DIAGNOSE		
- E.S.R.					- DRUG		
VOL							
PMA					PREGNANCY TEST		

CONFIRM IF THE APPLICATION BELONG OF THE FOLLOWING:	NO	YES
CONGENITAL DISEASES		
MENTAL DISORDER		
MENTAL DEFICIENCY		
MENTAL DISORDER		
BLINDNESS		
PARALYSIS		
DEAFNESS		
HEARING DISORDER		
SPEECH DISORDER		

MENTIONED ABOVE IS THE MEDICAL REPORT FOR MR / MISS / MRS: _____ , 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 TYPOWRITTEN LETTER SIGNED BY THE PHYSICIAN STATING THE CONDITION AND ANY TREATMENT IMPLEMENTED. THIS LETTER SHOULD ALSO INDICATE WHETHER THE CONDITION OR TREATMENT WILL HAVE ANY EFFECT ON THE APPLICANT'S WORK.

PHYSICIAN NAME: _____ SIGNATURE: _____
LICENSE NUMBER: _____ STAMP:
(THE FORM MUST BE ACCOMPANIED BY ONE OF THE DOCUMENTS LISTED BELOW)

THIS IS TO CERTIFY THAT DR. _____ LICENSE NUMBER _____ , IS CURRENTLY LICENSED TO PRACTICE MEDICINE. IN AUTHORIZED SIGNATURE :	STAMP OR SEAL OF THE STATE AUTHORITY (COUNCIL OF PHYSICIANS)

DEPARTMENT OF HEALTH
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SUBMIT TO THE COUNCIL OF METIONS THREE ORIGINAL COPIES OF THE MEDICAL REPORT AND TWO COPIES OF ALL PAGES TO OF THE MEDICAL TEST.
NO PART OF THIS REPORT MAY BE REPRODUCED IN THE HEALTH AUTHORITY COUNCIL OF PHYSICIANS WITHOUT THE EXPRESS WRITTEN PERMISSION OF THE COUNCIL OF PHYSICIANS.