

## **FOREIGN WORKER MEDICAL REPORT**

1) WORKER INFORMATION	
<b>Photo:</b>	
<b>Name:</b>	
<b>Passport Number:</b>	
<b>Nationality:</b>	
<b>Date Of Birth:</b>	
<b>Gender:</b>	
<b>Type Of Employment:</b>	
<b>Employer's Name:</b>	
<b>Employer's Address:</b>	
2) MEDICAL EXAMINATION DETAILS	
<b>Examination Date:</b>	
<b>Medical Facility Name:</b>	
<b>Address:</b>	
<b>Height(Cm):</b>	
<b>Weight(Kg):</b>	
<b>Blood Pressure(Mm/Hg):</b>	
<b>Pulse Rate(Bpm)</b>	
<b>Vision:</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Hearing:</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Physical examination:</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify:                      )
3) LABORATORY TESTS	
<b>Blood Test:</b>	a) Haemoglobin(g/dL): b) White Blood Cell Count(L): c) Platelet Count(L):
<b>Urine Test:</b>	a) Protein: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal b) Glucose: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Infectious Disease Screening:</b>	a) Tuberculosis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive b) Hepatitis B: <input type="checkbox"/> Negative <input type="checkbox"/> Positive c) HIV/AIDS: <input type="checkbox"/> Negative <input type="checkbox"/> Positive d) Syphilis: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
4) CHEST X-RAY FINDINGS	
<b>Date of X-Ray:</b>	
<b>Results:</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify:                      )
5) CONCLUSION AND RECOMMENDATION	
<b>Additional Remarks:</b>	
<b>Signature:</b>	
<b>Date:</b>	