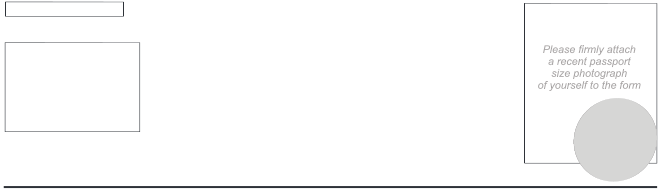
MOH-QA/F/17/67-4



*Name of Institute and address with Logo*

Medical Examination for

Work permit Visa

*Stamp of Institute*



1. Full Name



1. PP / IDC Number **3.** Date of Birth

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**4.**Nationality



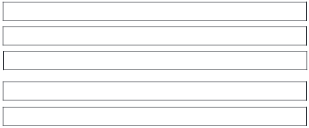
Male Single Divorced



**5.** Sex  **6**. Marital Status

Female Married Widow **Applicant’s medical history** No Yes

1. Have you ever had any serious illness or ►



major surgical operations?

1. Have you ever suffered from Tuberculosis? ►

►



1. Have you ever been diagnosed with leprosy? ►
2. Have you or has any member of your family ► been diagnosed with Leprosy?

**Applicant’s Declaration**

*I declare the information provided on this form is correct and have answered alI above, if I have given false or misleading information, I understand that my application may be rejected.*

*I consent to the facility passing on relevant sensitive information (including about my health) to the doctors who examined me, Ministry of Health , Health Protection Agency (HPA). The reasons for this release of information may include, but are not limited to, investigation and resolution of inconsistencies, complaints , audit recommendations or issues of public health concern.*

Applicant’s Signature



**Part B - Physical Examination -**



*Date Month Year*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |

Date of Examination

**1**. Blood pressure Systolic Diastolic



*(This section to be completed only for relevant occupations)*



*Without corr*.  *With corr*.

Right Eye 6/ 6/

Left Eye 6/ 6/

Color perception Normal Partially CB Totally CB



**3**. Leprosy Screening No Yes

Loss of sensation in skin patches *(If suspected, pls refer the patient to nearest dermatologist for confirmation)*



Deformity of hands, feet and eyes



due to previous leprosy infection



**Clinical Examination** *Normal Abnormal*



Cardiovascular ►Respiratory System ►



Digestive Organs ►

Skeleton, Bones & joint ►Mental Condition ►



Nervous System ►

Genitourinary System ►

Skin, Scar etc ►



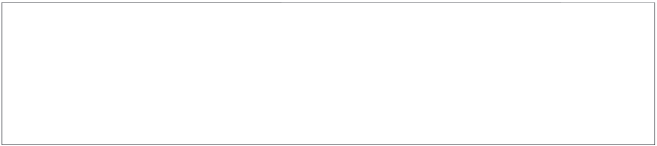
Teeth ►

Hearing ►



Gum ►

If Pregnant, Period of Pregnancy ►***For any abnormalities / positive findings please describe here***



**Part C - X- Ray Results**



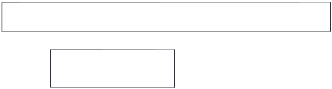
*Date Month Year*

Hospital / Clinic X- Ray Number Date



|  |  |  |  |  |  |  |  |
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Full name MAHC



Registration Number



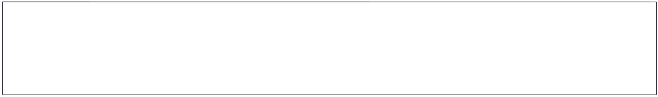
Radiographer’s

Signature *Date Month Year*

Date

|  |  |  |  |  |  |  |  |
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Radiological findings (to be reported by Radiologist / Pulmonologist / Physician)



Full name



Signature



Medical Examination for Work Permit Visa - MOH-QA/F/17/67-4

MMDC Registration Number

*Date Month Year*



Date

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**Part D - Laboratory Examination Results**



**Blood Analysis**

*Positive Negative* Hb g/dl VDRL



TC µl HBsAg

*Positive Negative*

Blood group (**A / B / AB / O**) HIV (\*optional)



HCV

**Urine Analysis**

Albumin Sugar **Laboratory Technologist’s Declaration**



MAHC



Full name Registration Number

Laboratory Technologist’s



Signature

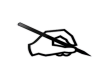
*Date Month Year*

Date Blood Sample Taken by:



|  |  |  |  |  |  |  |  |
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Full Name:



Designation: Signature:



**Certification by Doctor**

I certify that I have examined the above named person for the clinical examination and tests in part B, C & D and found that He / She is Fit / Unfit for employment in Maldives.

Full name MMDC



Registration Number

Doctor’s



Signature Date *Date Month Year*

|  |  |  |  |  |  |  |  |
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**Approved and Signed by**

Full name MMDC



Registration Number

Physician’s *Date Month Year* Signature Date



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