MOH-QA/F/17/67-4

Medical Examination for Work permit Visa

Name of Institute and address with Logo

Please firmly attach a recent passport size photograph of yourself to the form

Stamp of Institute

Part A - Applicant's details

To be filled by the applicant before attending the medical examination. Please write neatly using BLOCK LETTERS.

1. Full Name

2. PP / IDC Number

3. Date of Birth

4. Nationality

5. Sex — Male / Female

6. Marital Status — Single / Married / Divorced / Widow

Applicant's medical history

	No	Yes	
1. Have you ever had any serious illness or major surgical operations?			▶
2. Have you ever suffered from Tuberculosis?			▶
3. Have you or has any member of your family suffered from TB , fits or epilepsy?			▶
4. Have you ever been diagnosed with leprosy?			▶
5. 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 all 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 - *To be filled by the attending doctor*

Date of Examination (Date / Month / Year)

1. Blood pressure — Systolic — Diastolic

2. Ophthalmic findings *(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

To be filled by the Radiographer

Hospital / Clinic X- Ray Number

Date (Date / Month / Year)

Full name

MAHC Registration Number

Radiographer's Signature

Date (Date / Month / Year)

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

Full name

MMDC Registration Number

Signature

Date (Date / Month / Year)

Part D - Laboratory Examination Results

Blood Analysis

Hb ☐ g/dl

TC ☐ µl

	Positive	Negative
Blood group (**A / B / AB / O**) (*optional)	☐	☐

	Positive	Negative
VDRL	☐	☐
HBsAg	☐	☐
HIV	☐	☐
HCV	☐	☐

Urine Analysis

Albumin ☐ Sugar ☐

Laboratory Technologist's Declaration

I certify that I have confirmed the applicant's identity in terms of papers , photographs and appearance

Full name ☐ MAHC Registration Number ☐

Laboratory Technologist's Signature ☐

Date (Date / Month / Year) ☐☐ ☐☐ ☐☐☐☐

Blood Sample Taken by: 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) ☐☐ ☐☐ ☐☐☐☐

Approved and Signed by

Full name ☐ MMDC Registration Number ☐

Physician's Signature ☐

Date (Date / Month / Year) ☐☐ ☐☐ ☐☐☐☐