# MEDICAL EXAMINATIONS FORM

1. Medical examinations are required with the initial work permit application. The Medical examinations are valid for three (3) years.
2. Laboratory tests have to be repeated with each medical examination. The Laboratory Reports are valid for six (6) months.
3. Chest X-rays are required with the initial work permit application. Chest Xrays are valid for five (5) years.
4. Laboratory Reports have to be attached for HIV and VDRL tests.
5. Medical practitioners are advised to perform any tests that might be desirable depending on the disease prevalence in the respective countries.
6. The Medical Examinations Form must be signed and stamped or sealed by Physician.
7. The Laboratory Report must be signed and stamped or sealed by Lab Technician or Physician.
8. WORC Department reserves the right to require additional medical examinations at any time.

MEDICAL FORM CONTAINS 3 PAGES

## PART 1 - QUESTIONNAIRE (to be completed by Applicant)

1. (a) Surname (Last Name) _____ Given Names (First Names) _____ Maiden Name _____

(b) Nationality _____ (c) Country of Birth _____ (d) Date of Birth D/MMM/YY (e) Passport no _____

(f) Gender Male ☐ Female ☐ (g) Marital Status Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐

| 2. Have you ever had or currently have | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| (a) Nervous or mental trouble | ☐ | ☐ | (i) Eye trouble? | ☐ | ☐ |
| (b) Fits or convulsions? | ☐ | ☐ | (j) Any serious operation? | ☐ | ☐ |
| (c) Heart trouble or raised blood pressure? | ☐ | ☐ | (k) Diabetes? | ☐ | ☐ |
| (d) Lung tuberculosis, Asthma or hay fever? | ☐ | ☐ | (l) Rheumatic Fever? | ☐ | ☐ |
| (e) Contact with a case of tuberculosis? | ☐ | ☐ | (m) Family history of mental trouble, suicide, fits, any kind of tuberculosis, diabetes or raised blood pressure? | ☐ | ☐ |
| (f) Frequent or prolonged indigestion? | ☐ | ☐ | | | |
| (g) Malaria, dysentery or any other tropical illness? | ☐ | ☐ | (n) Any illness or injury not mentioned above? | ☐ | ☐ |
| (h) A sexually transmitted disease? | ☐ | ☐ | (o) A physical defect? | ☐ | ☐ |

If you have answered Yes to any part of questions 2, explain _____

3. Do you consume alcohol? ☐ Yes ☐ No

If Yes, how many alcoholic drinks do you typically consume in 1 week _____

4. Do you take habit forming drugs? ☐ Yes ☐ No

If Yes, explain _____

5. Have you ever applied for or received disability benefits? ☐ Yes ☐ No

If Yes, explain _____

6. Are you now in good health? Yes ☐ No ☐ If No, give details _____

7. Are you now pregnant? Yes ☐ No ☐ Not Applicable ☐ If Yes, how many months _____

Date (dd-mmm-yy) D/MMM/YY Signature of Applicant _____

Date (dd-mmm-yy) D/MMM/YY Medical Examiner/Physician _____

# MEDICAL EXAMINATION FORM

**PART 2 - MEDICAL EXAMINATION (to be completed by Medical Examiner)**

| | Yes | No |
|---|---|---|
| 1. Is the Examinee personally known to you? | ☐ | ☐ |
| If No, did you check ID? | ☐ | ☐ |

2. Height _____ feet _____ in. Weight _____ lbs. (in under clothes) Waist _____ in.

Chest measurements on respiration _____ in, on expiration _____ in.

3. Blood pressure (two readings: at rest (sitting) _____ lying down _____ Pulse rate _____

4. Date and report of last E.C.G. if any _____

| 5. Are the following free from any pathological condition or abnormality; | Yes | No |
|---|---|---|
| (a) Skin | ☐ | ☐ |
| (b) Throat & Mouth | ☐ | ☐ |
| (c) Eyes | ☐ | ☐ |
| (d) Ears | ☐ | ☐ |
| (e) Nose | ☐ | ☐ |
| (f) Abdomen | ☐ | ☐ |
| (g) Cardiovascular System | ☐ | ☐ |
| (h) Respiratory System | ☐ | ☐ |
| (i) Locomotor System | ☐ | ☐ |
| (j) Nervous System | ☐ | ☐ |
| (k) Genito-Urinary System | ☐ | ☐ |

If No to any of the above questions, provide details _____

6. Is the examinee on any drug therapy at present? Yes ☐ No ☐ If Yes, give details _____

7. Give details of any operations _____

8. Medical conditions a) _____ b) _____

c) _____ d) _____

Date of Examination (dd-mmm-yy) D/MMM/YY Signature Medical Examiner _____

# MEDICAL EXAMINATIONS FORM

**PART 3 - XRAY AND LABORATORY INVESTIGATIONS (to be completed by Medical Examiner**

(a) Hospital Xray No. _____ Date D/MMM/YY Result _____

(b) Urine: Date D/MMM/YY Albumin _____ Sugar _____

(c) Blood Tests (attach laboratory reports)

| TESTS | DATE | RESULT |
|---|---|---|
| VDRL | D/MMM/YY | |
| HIV SCREEN | D/MMM/YY | |

(d) Other tests (depending on history and disease prevalence in the country of origin)

| TESTS | DATE | RESULT |
|---|---|---|
| | D/MMM/YY | |
| | D/MMM/YY | |
| | D/MMM/YY | |

Name and address of Medical Examiner

Qualifications _____ Medical Registration Number _____

Address of Registering body _____

Date of Examination (dd-mmm-yy) D/MMM/YY Signature Medical Examiner _____