

KURNIYANTI

IC : AT408541 DOB : 29-Jan-1987

Sex : Female

PID : P183982



MINISTRY OF  
MANPOWER

Full Medical

Reg. Date : 16-Feb-19 11:41AM HP :

ers

All parts in this form are to be completed by the foreign worker.

must be endorsed by the doctor who identifies.

Part I Personal Particulars of Foreign Worker

Name: \_\_\_\_\_ Passport No. \_\_\_\_\_ Sex: \*Male / Female Height: 145 cm  
Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_ Weight: 44 kg

Part II Medical History (To be declared and signed by the foreign worker)

|                     | Yes                      | No                                  | If yes, give brief details |                 | Yes                      | No                                  | If yes, give brief details |
|---------------------|--------------------------|-------------------------------------|----------------------------|-----------------|--------------------------|-------------------------------------|----------------------------|
| 1 Mental illness    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | 6 Tuberculosis  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            |
| 2 Epilepsy          | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | 7 Heart Disease | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            |
| 3 Chronic Asthma    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | 8 Malaria       | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            |
| 4 Diabetes Mellitus | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            | 9 Operations    | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            |
| 5 Hypertension      | <input type="checkbox"/> | <input checked="" type="checkbox"/> |                            |                 |                          |                                     |                            |

I declare that all the information given above is true and correct. I hereby give my consent for a copy of this medical form after it is completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted in my work permit application.

Signature of Foreign Worker

Date

16 FEB 2019

Part III Please tick if any of the Examinations / Tests is Abnormal and give brief details separately.

| Clinical Examinations                                                                                                                                                                             | Abnormal                 | Other Tests                                                                                                                                                                                    | Abnormal                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 1 Cardiovascular System                                                                                                                                                                           |                          | 1 Chest X-ray – to be taken in Singapore (*For any abnormalities and other findings including no active lung lesion, please state here and attach the chest radiological report to this form.) | <input type="checkbox"/> |
| a Blood Pressure                                                                                                                                                                                  | <input type="checkbox"/> |                                                                                                                                                                                                |                          |
| Systolic: <u>121/81</u>                                                                                                                                                                           |                          |                                                                                                                                                                                                |                          |
| Diastolic: <u>81</u>                                                                                                                                                                              |                          |                                                                                                                                                                                                |                          |
| b Heart Disease                                                                                                                                                                                   | <input type="checkbox"/> | 2 Urine                                                                                                                                                                                        | <input type="checkbox"/> |
| c ECG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardiac murmurs or symptoms suggestive of Myocardial ischaemia) | <input type="checkbox"/> | a Albumin                                                                                                                                                                                      | <input type="checkbox"/> |
| d Severe varicose veins                                                                                                                                                                           | <input type="checkbox"/> | b Sugar                                                                                                                                                                                        | <input type="checkbox"/> |
| 2 Anaemia (if clinically anaemic, do HB: _____ g%)                                                                                                                                                | <input type="checkbox"/> | c Pregnancy                                                                                                                                                                                    | <input type="checkbox"/> |
| 3 Respiratory System                                                                                                                                                                              | <input type="checkbox"/> | 3 VDRL                                                                                                                                                                                         | <input type="checkbox"/> |
| 4 Abdomen                                                                                                                                                                                         |                          | 4 Hearing – unable to hear ordinary conversation at 2m                                                                                                                                         | <input type="checkbox"/> |
| a Hernia                                                                                                                                                                                          | <input type="checkbox"/> | 5 Vision (should be at least 6/12 in both eyes with or without glasses.)                                                                                                                       | <input type="checkbox"/> |
| b Enlarged Liver                                                                                                                                                                                  | <input type="checkbox"/> | a Vision Acuity                                                                                                                                                                                | <input type="checkbox"/> |
| c Enlarged Spleen                                                                                                                                                                                 | <input type="checkbox"/> | i) Right eye                                                                                                                                                                                   | <input type="checkbox"/> |
| d Genito-Urinary System                                                                                                                                                                           | <input type="checkbox"/> | ii) Left eye                                                                                                                                                                                   | <input type="checkbox"/> |
| 5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)                                                                                                                          | <input type="checkbox"/> | b Colour Vision (for electricians & drivers only)                                                                                                                                              | <input type="checkbox"/> |
| 6 Locomotor/Neurological                                                                                                                                                                          |                          | c Any organic eye disease, e.g. Trachoma                                                                                                                                                       | <input type="checkbox"/> |
| a Significant limb amputation or deformity                                                                                                                                                        | <input type="checkbox"/> | 6 Blood film for Malaria                                                                                                                                                                       | <input type="checkbox"/> |
| b Limb movement and co-ordination                                                                                                                                                                 | <input type="checkbox"/> | 7 HIV (AIDS)                                                                                                                                                                                   | <input type="checkbox"/> |
| c Significant spinal deformity                                                                                                                                                                    | <input type="checkbox"/> | Note:                                                                                                                                                                                          |                          |
| d Other significant abnormalities (in relation to the Work required to be performed)                                                                                                              | <input type="checkbox"/> | HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.                                                                                    |                          |
| 7 Endocrine disorders, e.g. thyrotoxicosis                                                                                                                                                        | <input type="checkbox"/> |                                                                                                                                                                                                |                          |
| 8 Mental state                                                                                                                                                                                    | <input type="checkbox"/> |                                                                                                                                                                                                |                          |

Part IV Certification from the Doctor

I certify that I have examined the above-named foreign worker for the clinical examinations / tests in Part III and found that this person is \*Fit / Unfit for employment in the above-stated occupation.

Name of Doctor: Winnie Medical Pte Ltd

Signature of Doctor:

Clinic Address: Blk 81 Macpherson Lane #01-35

Date:

Singapore 360081

Telephone Number:

Tel: 6842 7842 Fax: 6743 0954

Dr Foo Jong Hiang

MCR: 08896Z

18 FEB 2019

\*Delete where inapplicable

Doctors to Note:

Please send the completed medical form back to the employer / employment agent promptly, so that they can get the work pass issued.