

Kingston Medical (Created by: 11108) - Visit Label

Form For Foreign Workers

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

NAME: NENG SIAN CHING
NRIC/PP No: MJ274988
NATIONALITY: Myanmar
D.O.B: 07/08/2000 SEX: Female
OCCUPATION: FDW
((GLOBAL UNITED))
WOP5

Medical history must be reviewed by a registered doctor. Any amendments must be endorsed by the doctor who reviewed the medical history for identification.

Name: _____

No. _____ Sex: *Male / Female

Height: 151 cm

Occupation: _____

Birth: _____ Citizenship: _____

Weight: 43 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.

mjs

18 OCT 2024

Signature of Foreign Worker

Date

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: 117/78			
Diastolic: 78			
b Heart Disease	<input type="checkbox"/>	Declare Not Pregnant	
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"/>	L.M.P: 5/10/24 Patient's Signature: <i>mjs</i>	
d Severe varicose veins	<input type="checkbox"/>		
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	2 Urine	<input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	a Albumin	<input type="checkbox"/>
4 Abdomen		b Sugar	<input type="checkbox"/>
a Hernia	<input type="checkbox"/>	c Pregnancy	<input type="checkbox"/>
b Enlarged Liver	<input type="checkbox"/>	3 VDRL	<input type="checkbox"/>
c Enlarged Spleen	<input type="checkbox"/>	4 Hearing – unable to hear ordinary conversation at 2m	<input type="checkbox"/>
d Genito-Urinary System	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.)	<input type="checkbox"/>
5 Skin-Chronic Disease (e.g. leprosy, widespread eczema, psoriasis, etc)	<input type="checkbox"/>	a Vision Acuity	<input type="checkbox"/>
6 Locomotor/Neurological		i) Right eye] 6/12	<input type="checkbox"/>
a Significant limb amputation or deformity	<input type="checkbox"/>	ii) Left eye] 6/12	<input type="checkbox"/>
b Limb movement and co-ordination	<input type="checkbox"/>	b Colour Vision (for electricians & drivers only)	<input type="checkbox"/>
c Significant spinal deformity	<input type="checkbox"/>	c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/>	6 Blood film for Malaria	<input type="checkbox"/>
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>	7 HIV (AIDS)	<input type="checkbox"/>
8 Mental state	<input type="checkbox"/>	Note:	
		HIV (AIDS) Test and blood film for Malaria must be done at laboratories approved by the Ministry of Health.	

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: DR POH WEE MIN MCR:06332J MBBS

Signature of Doctor: *P*

Clinic Address: KINGSTON MEDICAL CLINIC PTE LTD

Date: 18 OCT 2024

250 SIMS AVENUE #01-01, SINGAPORE 387513

Telephone Number: +65 88612806

*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.



KINGSTON MEDICAL GROUP

Kingston Medical Imaging

250 Sims Ave SPCS Building #01-01 Singapore 387513

RADIOLOGY REPORT

Name	: NENG SIAN CHING	Study Date	: 2024-10-18
NRIC No	: MJ274988	Accession No.	: KMA24070864MNO
Age/Sex	: F/24Y2M	Referral Doctor	: DR POH WEE MIN

CHEST PA

CHEST X-RAY

No active lung lesions.
The heart size is normal

DR MARK TAN
MBBS (S'pore), FRCR (UK), MMed, FAMS,
Senior Consultant Radiologist

2024-10-18 17:41:12

*This is a computer generated report. No signature is required
Please seek medical advice if result is abnormal*

NENG SIAN CHING [Female / 24 years]

KINGSTON MEDICAL CLINIC PTE LTD (SIMS AVE)

250 SIMS AVE

#01-01 SPCS BUILDING

SINGAPORE 387513

DR POH WEE MIN

Area : GEY KING07

NRIC/FIN/PP : MJ274988**MRN/Ref No** : KMGP24067589**Lab ID** : 24AW8699**Date Received** : 18-Oct-2024 17:55**Report #** : 1857513**Date Reported** : 18-Oct-2024 22:56**Test Ordered** : WOP5

TEST		RESULT	REF. RANGE
WORK PERMIT SCREEN			
Malarial parasites	疟原虫	Negative	(Negative)
HIV Ag/Ab	爱滋病抗原/抗体	Non-reactive	(Non-reactive)
VD (Syphilis TP Ab)	梅毒检验	Non-reactive	(Non-reactive)