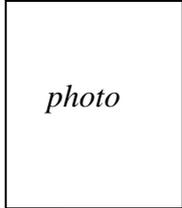


**MEDICAL REPORT FOR FOREIGN WORKER
FOR EMPLOYMENT IN BRUNEI DARUSSALAM**

*(in accordance with The Infectious Diseases Order; Immigration Act and
Labor Act of the Statutes of Brunei Darussalam)*



Accreditation no:.....

Ref. no.:.....

**Part 1 : Personal Information
(This part is to be completed by the applicant)**

1. FULL NAME:

.....
(please underline surname)

2. SEX: MALE / FEMALE 3. DATE OF BIRTH : 4. PASSPORT NO:.....

5. TYPE OF JOB APPLIED :

6. ADDRESS IN COUNTRY OF ORIGIN :

.....

7. NAME OF EMPLOYER / RECRUITING AGENCY :

8. FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY:

.....

**PART II : MEDICAL HISTORY
(To be completed by the attending physician)**

Has the worker ever suffered from or experienced or received treatment for the following diseases and conditions? If "YES", please indicate dates of detection and treatment received.

	YES	NO	DATE/TREATMENT
1 HIV / AIDS *			
2 TUBERCULOSIS *			
3 EPILEPSY *			
4 LEPROSY*			
5 SEXUALLY TRANSMITTED INFECTIONS *			
6 PSYCHIATRIC ILLNESS *			
7 HEPATITIS B*			
8 DRUG USE *			
9 DIABETES MELLITUS **			
10 HYPERTENSION **			
11 CANCER **			
12 BRONCHIAL ASTHMA **			
13 HEART DISEASE **			
14 KIDNEY DISEASE **			
15 HEARING PROBLEM**			
16 VISION PROBLEM**			
17 PEPTIC ULCER**			
18 MALARIA			
19 OTHERS (Please state)			

* To be considered unfit if answered 'yes' to any of the item

** Fitness up to the discretion of the attending Physician; must indicate severity, complications and medications currently taken by the applicant

PART III : PHYSICAL EXAMINATION AND INVESTIGATIONS
(To be completed by the attending physician)

Section A : General Physical Examination

1. Height : _____ cm 2. Weight : _____ kg 3. Pulse : _____/min

4. Blood pressure : _____ mmHg (Systolic /Diastolic)

	PRESENT	ABSENT
5 Chronic skin rash/sores on hands		
6 Anaesthetic skin patch		
7 Deformities of limbs		
8 Anaemia		
9 Jaundice		
10 Lymph node enlargement		
	RIGHT	LEFT
11 Hearing impairment		
12 Vision test		
Unaided		
Aided		
Colour blindness	PRESENT	ABSENT

Section B : Systemic Examination

	Normal	Abnormal
1 Cardiovascular System		
1.1. Heart Size		
1.2. Heart Sounds		
1.3. Other Findings _____		
2 Respiratory System		
2.1. "Breath Sounds"		
2.2. Other Findings _____		
3 Gastrointestinal System		
3.1. Liver		
3.2. Spleen		
3.3. Kidney		
3.4. Is there any abnormal swelling? YES / NO Indicate if "YES"		

3.5. Rectal Examination		
4 Central Nervous System	Normal	Abnormal
4.1. General Mental Status		
4.2. Speech		
4.3. Cognitive Function		
4.4. Motor power		
4.5. Sensory		
4.6. Reflexes		
5 Genitourinary System	YES	NO
5.1. Discharge		
5.2. Sores / Ulcers		

Section C : Laboratory Results and X-ray Findings

	Negative	Positive
1 Blood		
1.1. HIV Antibody #		
1.2. HbsAg #		
1.3. VDRL /TPHA #		
1.4. Malaria Parasite		

If positive for malaria, give appropriate treatment and then repeat 1.4

Date when blood test for malaria parasite is found negative after treatment : _____

2. Urine Examination		
2.1. Urine Examination - Colour : _____ Specific Gravity : _____		
Sugar	Negative	Positive
Albumin		

Microscopic Examination : _____

Others: _____

2.2. Opiates / Cannabis #		
2.3. Pregnancy #		

	Normal	Abnormal
3 Chest X-Ray Report (Large film) (valid for 6 months- UNFIT IF ANY ABNORMALITY IN THE LUNG FIELDS are present)		

	Negative	Positive
4 Stool examination # [for those handling food]		
<i>Salmonella Typhi</i>		
<i>V.Cholera</i>		
<i>V.Parahaemolyticus</i>		
<i>Shigella</i>		
<i>E.Histolytica</i>		
<i>Other enteropathogens (please state)</i>		

If positive for any of the above, give appropriate treatment and then repeat stool exam

Date when stool exam is found negative for all of the above after treatment : _____

5 Sputum AFB (if indicated)	POSITIVE	NEGATIVE
6 ECG (if indicated)	NORMAL	ABNORMAL
7 Slit skin smear (if indicated)	POSITIVE	NEGATIVE

To be considered unfit if found positive/ abnormal

PART IV: VACCINATIONS GIVEN (IF APPLICABLE)

	Vaccine	Batch no.	Given by
1. Typhoid/Paratyphoid	_____	_____	_____
2. Tetanus	_____	_____	_____
3. Hepatitis B	_____	_____	_____
4. Others (Please state)	_____	_____	_____

PART V: CERTIFICATION BY PHYSICIAN

I HAVE EXAMINED THE ABOVENAMED APPLICANT AND FOUND THAT HE / SHE IS FREE FROM THE FOLLOWING DISEASES:

	YES	NO
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
MALARIA	<input type="checkbox"/>	<input type="checkbox"/>
LEPROSY	<input type="checkbox"/>	<input type="checkbox"/>
SEXUALLY TRANSMITTED INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS B	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATE / CANNABIS.

SHE IS / IS NOT PREGNANT (IF APPLICABLE)

HE / SHE HAS / HAS NOT BEEN GIVEN THE APPROPRIATE VACCINATIONS (IF APPLICABLE)

HE / SHE IS **FIT / UNFIT** TO BE EMPLOYED IN THE JOB THAT HE / SHE IS APPLYING FOR

I THEREFORE RECOMMEND THAT HE / SHE BE **CONSIDERED / NOT CONSIDERED** FOR EMPLOYMENT (IF NOT CONSIDERED FOR EMPLOYMENT PLEASE STATE THE REASON(S) BELOW)

SIGNATURE

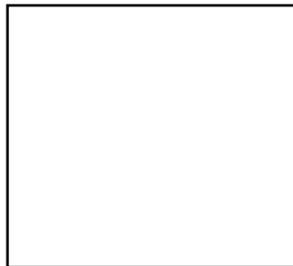
DATE

NAME OF CERTIFYING PHYSICIAN: _____

ADDRESS OF PHYSICIAN: _____

QUALIFICATIONS: _____

OFFICIAL STAMP



(TO BE RETAINED BY THE EXAMINING PHYSICIAN)



MINISTRY OF HEALTH BRUNEI DARUSSALAM
MEDICAL CERTIFICATE FOR FOREIGN WORKER
(Please attach all results of investigations, X-Ray and radiologist report)

Accreditation no:.....

Ref.no:.....

1. FULL NAME:
(please underline surname)
2. SEX: MALE / FEMALE 3. DATE OF BIRTH : 4. PASSPORT NO:.....
5. TYPE OF JOB APPLIED :
6. FULL ADDRESS IN COUNTRY OF ORIGIN :.....
.....
7. NAME AND FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY.....
.....

I HAVE EXAMINED THE ABOVE NAMED APPLICANT AND FOUND THAT HE / SHE IS FREE FROM THE FOLLOWING DISEASES:

- HIV / AIDS
- TUBERCULOSIS
- MALARIA
- LEPROSY
- SEXUALLY TRANSMITTED INFECTIONS
- HEPATITIS B
- EPILEPSY
- PSYCHIATRIC ILLNESS

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATE / CANNABIS

SHE IS NOT PREGNANT (IF APPLICABLE)

HE / SHE HAS BEEN GIVEN THE APPROPRIATE VACCINATIONS (PLEASE STATE IF GIVEN)

HE / SHE IS **FIT** TO BE EMPLOYED IN THE JOB THAT HE / SHE IS APPLYING FOR
I THEREFORE RECOMMEND THAT HE / SHE BE **CONSIDERED** FOR EMPLOYMENT

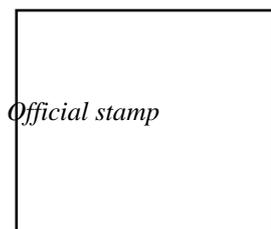
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DATE

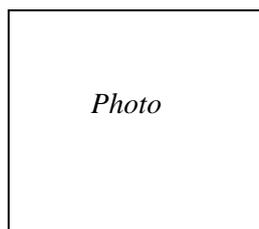
NAME OF CERTIFYING PHYSICIAN:_____

ADDRESS OF PHYSICIAN:_____

QUALIFICATIONS:_____ TEL.NO:_____ FAX NO:_____



Official stamp



Photo

(TO BE RETAINED BY THE WORKER)
VALID ONLY FOR THREE MONTHS FROM THE DATE OF ISSUE

**FOR OFFICIAL USE ONLY BY THE EMBASSY/HIGH COMMISSION/CONSULATE
OR REPRESENTATIVE OFFICE OF BRUNEI DARUSSALAM**

Accreditation no:.....

Ref.no:.....

1. FULL NAME:
(please underline surname)

2. SEX: MALE / FEMALE 3. DATE OF BIRTH : 4. PASSPORT NO:.....

5. TYPE OF JOB APPLIED :

6. ADDRESS IN COUNTRY OF ORIGIN :

.....

7. NAME OF EMPLOYER / RECRUITING AGENCY :

.....

8. FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY :

.....

I HAVE PERUSED THE ABOVE APPLICANT'S PRE-EMPLOYMENT MEDICAL DOCUMENTS AND FOUND THAT THE RECORDS ARE / ARE NOT IN ORDER AND HEREBY:

- ISSUE
- NOT ISSUE

AN EMPLOYMENT ENTRY VISA.

VISA NUMBER ISSUED: _____

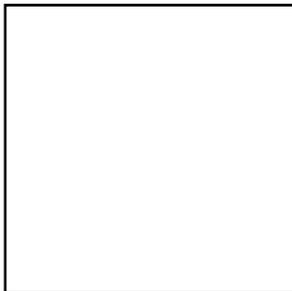
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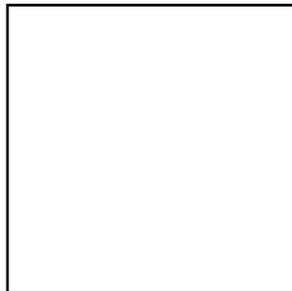
NAME OF OFFICIAL: _____

DESIGNATION: _____

APPLICANT'S PHOTO



OFFICIAL STAMP



(TO BE RETAINED AT THE ABOVE OFFICE FOR FUTURE REFERENCE)