**MEDICAL REPORT FOR FOREIGN WORKER**

 *photo*

**FOR EMPLOYMENT IN BRUNEI DARUSSALAM**

*(in accordance with The Infectious Diseases Order; Immigration Act and*

*Labour Act of the Statutes of Brunei Darussalam)*

###### Accreditation no: …………………… Ref. no.: ……………..…………………

**PART I: PERSONAL INFORMATION**

**(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 examining 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 | HEPATITIS C \* |  |  |  |
| 9 | DRUG USE \* |  |  |  |
| 10 | DIABETES MELLITUS \*\* |  |  |  |
| 11 | HYPERTENSION \*\* |  |  |  |
| 12 | CANCER \*\* |  |  |  |
| 13 | BRONCHIAL ASTHMA \*\* |  |  |  |
| 14 | HEART DISEASE \*\* |  |  |  |
| 15 | KIDNEY DISEASE \*\* |  |  |  |
| 16 | HEARING PROBLEM \*\* |  |  |  |
| 17 | VISION PROBLEM \*\* |  |  |  |
| 18 | PEPTIC ULCER \*\* |  |  |  |
| 19 | MALARIA |  |  |  |
| 20 | OTHERS  |  |  |  |
|  |

***\* To be considered unfit if answered ‘yes’ to any of the items***

*\*\*Fitness is 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 examining physician)**

**Section A: General Physical Examination**

1. Height: \_\_\_\_\_\_cm 2. Weight: \_\_\_\_\_\_\_ kg 3. Pulse: \_\_\_\_\_\_\_\_\_\_\_ /min
2. Blood pressure : \_\_\_\_\_\_\_\_\_\_ mmHg (Systolic/Diastolic)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Present** | **Absent** |
| 5 | Chronic skin rash/sores on hands |  |  |
| 6 | Deformities of limbs |  |  |
| 7 | Anaemia |  |  |
| 8 | Jaundice |  |  |
| 9 | Lymph node enlargement |  |  |
| 10 | Hearing impairment |  |  |
| 11 | Vision test |  |  |
|  |  Unaided |  |  |
|  |  Aided |  |  |
|  |  Colour blindness |  |  |

**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 |  |  |
|  | 1. 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. HCV # |  |  |
|  | 1.4. VDRL/ TPHA **#** |  |  |
|  | 1.5. Malaria Parasite |  |  |

If positive for malaria, give appropriate treatment and then repeat 1.5

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

1. Urine Examination

 2.1. Colour: \_\_\_\_\_\_\_\_\_\_\_\_

 2.2. Specific Gravity: \_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Negative** | **Positive** |
|  | 2.3. Sugar  |   |  |
|  | 2.4. Albumin |  |  |
|  | 2.5. Microscopic Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

 2.6. Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  |  2.7. Opiates # |  |  |
|  |  2.8. Cannabis **#** |  |  |
|  |  2.9. Methaphetamines # |  |  |
|  |  2.10. Benzodiazepines # |  |  |
|  |  2.11. Pregnancy **#** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 3 | Chest X-Ray Report (valid for 6 months) - **UNFIT IF ANY ABNORMALITY IN THE LUNG FIELDS** are present)  | **Normal** | **Abnormal** |
|  |  |  |  |
| 4 | Stool examination # [for those handling food] | **Negative** | **Positive** |
|  | *Salmonella Typhii* |  |  |
|  | *V.Cholera* |  |  |
|  | *V.Parahaemolyticus* |  |  |
|  | *Shigella* |  |  |
|  | *E.Histolytica* |  |  |
|  | *Other enteropathogens (please state)* |  |  |

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

Date when stool examination is found negative for all of the above after treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5 Sputum AFB (if indicated) **Negative Positive**

6 ECG (if indicated)  **Normal Abnormal**

7 Slit skin smear (if indicated) **Negative Positive**

***# 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 EXAMINING PHYSICIAN

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

 YES NO

 HIV / AIDS

TUBERCULOSIS

MALARIA

LEPROSY

SEXUALLY TRANSMITTED INFECTIONS

HEPATITIS B

HEPATITIS C

EPILEPSY

PSYCHIATRIC ILLNESS

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATES / CANNABIS / METHAMPHETAMINES / BENZODIAZEPINES.

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)***

**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 / RECRUTING 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE DATE

NAME OF OFFICIAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESIGNATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APPLICANT’S PHOTO OFFICIAL STAMP

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

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# 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

 HEPATITIS C

 EPILEPSY

 PSYCHIATRIC ILLNESS

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATES / CANNABIS / AMPHETAMINES / BENZODIAZEPINES

SHE IS NOT PREGNANT (IF APPLICABLE)

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE DATE

NAME OF CERTIFYING PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS OF PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

QUALIFICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TEL.NO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX NO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###  *Photo*

 *Official stamp*

VALID ONLY FOR 180 DAYS FROM THE DATE OF ISSUE