MEDICAL REPORT FOR FOREIGN WORKER FOR EMPLOYMENT IN BRUNEI DARUSSALAM

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

photo

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

4. 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		
	3.4. Is there any abnormal swelling? (YES/NO) Indicate if 'YES'		
	_____		
	3.5. Rectal Examination		

		Normal	Abnormal
4	Central Nervous System		
	4.1. General Mental Status		
	4.2. Speech		
	4.3. Cognitive Function		
	4.4. Motor power		
	4.5. Sensory		
	4.6. Reflexes		

		Yes	No
5	Genitourinary System		
	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: _____

2. 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 #		

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

		Negative	Positive
4	Stool examination # [for those handling food]		
	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)

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:_____

Official stamp	*Photo*

VALID ONLY FOR 180 DAYS FROM THE DATE OF ISSUE