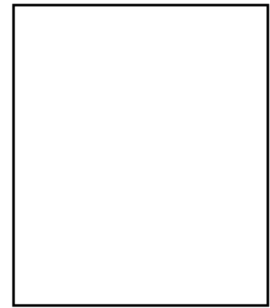

MEDICAL EXAMINATION FOR FITNESS (VISA)

PART – A

APPLICANT DETAILS (To be filled by applicant in BLOCK LETTERS)

1. **Full Name (as in Passport) :**

2. Passport Number :

3. Date of Birth :

4. Nationality :

5. Sex :

6. Marital Status :

7. COVID Vaccination :

MEDICAL HISTORY

	NO	YES	If YES, specify details
1. Have you ever had any serious illness or major surgery?			
2. Have you ever suffered from Tuberculosis?			
3. Have you or any family member suffered from Tuberculosis or epilepsy?			

APPLICANT'S DECLARATION

I declare the information provided on this form is correct and have answered all above, if I have given false or misleading information, I understand my application will be rejected.

I consent to the facility passing on relevant information to the doctors who examined me.

Applicant's Signature

PART – B

PHYSICAL EXAMINATION – To be filled by the attending doctor

DATE OF EXAMINATION:

1. Blood pressure:

2. Ophthalmic findings:

	Without correction	With correction
Right Eye		
Left Eye		

Colour perception Normal ☐ Partially CB ☐ Totally CB ☐

3. Systemic Examination

	Normal	Abnormal	If abnormal, please specify
Head and Neck			
Hearing			
Gums and Teeth			
Cardiovascular system			
Respiratory system			
Abdomen			
Genitourinary system			
Skeleton, Bones and joint			
Mental condition			
Nervous system			
Skin			
If Pregnant (period of pregnancy)			

ANY OTHER ABNORMALITIES / POSITIVE FINDINGS (please specify in the box below)

PART – C

RADIOLOGICAL FINDINGS – To be filled by Radiographer

DATE OF EXAMINATION:

Hospital Number

Full Name :

Registration Number :

Radiographer's Signature

Radiological findings to be reported by the RMP.

Full Name :

Registration Number :

Signature

PART – D

BLOOD ANALYSIS

DATE OF EXAMINATION:

			Reactive	Non-reactive
Hb.		VDRL		
TC		HBsAg		
Blood Group		HIV		

URINE ANALYSIS

Albumin		Sugar	

LABORATORY TECHNOLOGIST'S DECLARATION

I certify that I have confirmed the applicant's identity in terms of papers, photographs and appearance.

Full Name :

Registration Number :

Laboratory Technologist's Signature

CERTIFICATION BY DOCTOR

I certify that I have examined the above named person for the clinical examination and tests in Part B, C and D and found that **HE / SHE** is **FIT / UNFIT** for employment.

Full Name:

Registration Number:

Date:

Doctor's Signature