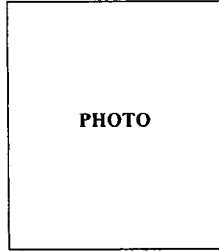




MEDICAL REPORT نموذج تقرير طبي



NAME: _____
 NATIONALITY: _____ SEX: _____ AGE: _____ MARITAL STATUS: _____
 PASSPORT NO: _____ ISSUE PLACE: _____ ISSUE DATE: _____
 POSITION APPLIED FOR: _____

DEAR SIR / MADAM
 PLEASE, ARRANGE TO EXAMINE THE ABOVE MENTIONED CANDIDATE AS TO HIS/HER FITNESS FOR THE ABOVE MENTIONED POSITION.

DATE ___/___/___ RECRUITMENT ATTACHE/OR DOCTOR: _____

HISTORY OF ANY SIGNIFICANT PAST ILLNESS INCLUDING:

- PSYCHIATRIC AND NEUROLOGICAL DISORDERS (EPILEPSY, DEPRESSION...)

- ALLERGY

MEDICAL EXAMINATION			LABORATORY INVESTIGATION				
TYPE OF MEDICAL EXAMINATION		NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL	TYPE OF LABORATORY INVESTIGATION	NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL	
VISION	R. EYE			(URINE)			
	L. EYE				- SUGAR		
EYE					- ALBUMIN		
	OTHER				- BILHARZIASIS		
EAR	R. EAR			(STOOL)			
	L. EAR				- HELMINTHES		
					- SALMONELLA/SHIGELLA		
CHEST X - RAY					- V.CHOLERA		
PULMONARY TUBERCULOSIS					- OTHER		
(SYSTEMIC EXAMINATION)				(BLOOD)			
BLOOD PRESSURE					- HEMOGLOBIN		
HEART					- MALARIA FILM		
LUNGS					- OTHERS		
ABDOMEN				(SEROLOGY)			
(OTHERS)					- HIV TEST		
*HERNIA							
*VARICOSE VEINS							
EXTREMITIES					- F. B. S.		
SKIN					- HBSAG/ANTI HCV		
(VENEREAL DISEASES)					- L. F. T.		
- CLINICAL					- CREATININE		
- LAB					- UREA		
VDRL				PREGNANCY TEST			
TPHA							

CONFIRM IF THE APPLICATION HAS ONE OF THE FOLLOWING:

	NO	YES
COMMUNICABLE DISEASES		
MENTAL DISORDER		
MENTAL RETARDATION		
PHYSICAL DISORDERS		
HANDICAP		
PARALYSIS		
BLINDNESS		
HEARING DISORDER		
SPEECH DISORDER		

MENTIONED ABOVE IS THE MEDICAL REPORT FOR MR / MRS / MISS _____, WHO IS
 [] FIT [] UNFIT FOR THE ABOVE MENTIONED JOB.
 - TO BE FIT, ALL MEDICAL EXAMINATIONS AND LABORATORY INVESTIGATIONS MUST BE WITHIN NORMAL LIMITS. IN THE EVENT OF AN ABNORMAL/POSITIVE RESULT, A TYPEWRITTEN LETTER SIGNED BY THE PHYSICIAN STATING THE CONDITION AND ANY TREATMENT IMPLEMENTED. THIS LETTER SHOULD ALSO INDICATE WHETHER THIS CONDITION OR TREATMENT WILL HAVE ANY EFFECT ON THE APPLICANT'S WORK.

PHYSICIAN NAME: _____ SIGNATURE: _____
 LICENSE NUMBER: _____ STAMP: _____

THIS FORM MUST BE ATTESTED BY ONE OF THE TWO FOLLOWING AUTHORITIES:

THIS IS TO CERTIFY THAT DR. _____ LICENSE NUMBER: _____, IS CURRENTLY LICENSED TO PRACTICE MEDICINE. (1)	DEPARTMENT OF HEALTH (2)
AUTHORIZED SIGNATURE : _____	STAMP OR SEAL OF THE STATE AUTHORITY (COLLEGE OF PHYSICIANS)