MEDICAL REPORT نموذج تقـرير طبـي

PHOTO	NAME						
	NATIONALITY		SEX		AGE		MARITAL STATUS	
	PASSPORT NO.		PLACE & DATE OF ISSUE				
	POSITION APPLIED FOR						

DEAR SIR, MADAM

PLEASE , ARRANGE TO EXAMINE THE ABOVE MENTIONED CANDIDATE WHETHER HE/SHE IS FIT FOR THE ABOVE MENTIONED POSITION .

DATE __/__/____ RECRUTEMENT ATTACHE/OR DOCTOR:

HISTORY OF ANY SIGNIFICANT PAST ILLNESS INCLUDING :

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

MEDICAL EXAMINATION

TYPE OF MEDICAL EXAMINATION			NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL
	VISION	R.EYE		
		L.EYE		
EYE				
	OTHER	R.EYE		
		L.EYE		
EAR		R.EAR		
		L.EAR		
CHEST X - RAY				
PULMONARY TUBERCULOSIS				
[SYSTEMIC EXAMINATION]				
BLOOD PRESSURE				
HEART				
LUNGS				
ABDOMEN				
[OTHERS]				
* HERNIA				
* VARICOSE VAINS				
EXTREMITIES				
SKIN				
[VENERAL DISEASES]				
- CLINICAL				
- LAB				
VDRL				
TPHA				

LABORATORY INVESTIGATION

TYPE OF LABORATORY INVESTIGATION	NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL
[URINE]		
-SUGAR		
- ALBUMIN		
- BILHARZIASIS		
- OTHER		
[STOOL]		
- HELMINTHES		
- SALMONELLA/SHIGELLA		
- V.CHOLERA		
- OTHER		
[BLOOD]		
- HAEMOGLOBIN		
- MALARIA FILM		
- OTHERS		
[SEROLOGY]		
- HIV TEST(FROM A PROVINCIAL LAB.)		
- F.B.S.		
- HBsAG/ANTI HCV		
- L.F.T.		
- CREATININE		
- UREA		
PREGNANCY TEST		

CONFIRM IF THE APPLICANT HAS ONE OF THE FOLLOWING:	NO	YES
COMMUNICABLE DISEASES		
MENTAL DISORDER		
MENTAL RETARDATION		
PHYSICAL DISORDERS		
HANDICAP		
PARALYSIS		
BLINDNESS		
DEAFNESS		
DUMBNESS		

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. A CHECK MARK ( ), ONLY, MUST BE INSERTED IN THE NEGATIVE \NORMAL SECTIONS ABOVE. IN THE EVENT OF ANY POSITIVE TEST RESULTS A TYPED & SIGNED NOTE FROM THE DOCTOR STATING IF THIS IS A COMMUNICABLE OR NON COMMUNICABLE DISEASE AND TO ADVISE US OF TREATMENT UNDER TAKEN AND IF IT HAS ANY EFFECT ON THE APPLICANT'S WORK.

SUBMIT TO THE CONSULAR SECTION ORIGINALS AND COPIES OF THIS REPORT AND THE TESTS RESULTS . DO NOT SUBMIT X-RAY'S AS THOSE MUST BE PRESENTED TO THE HEALTH AUTHORITIES IN SAUDI ARABIA ALONGWITH ONE CLEAR COPY OF THIS REPORT AND ALL TEST RESULTS.

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 MEDECINE .

(1)

AUTHORIZED SIGNATURE	STAMP OR SEAL OF THE PROVINCIAL LICENSING AUTHORITY (college of physicians)

DEPARTMENT OF HEALTH (FEDERAL OR PROVINCIAL)

(2)

NOTE:

IF THE TEST RESULT DOES NOT SHOW A NEGATIVE SIGN AND GIVES STANDARD COMMENTS YOU ARE REQUESTED TO HAVE EITHER THE LAB. OR THE DOCTOR INDICATE THE RESULT OF NEGATIVE OR POSITIVE ON THE TEST REESULT IT SELF & MUST BE SIGNED. IN CASE OF POSTIVE A FULL TYPED EXPLANTION IS REQUIRED.