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i. Health Declaration – to be completed by staff

ii. Medical Examination – to be completed by a certified physician

Note: Staff is responsible to return this form to HCAD UTS after completion.

**PERSONAL DETAILS**

**Name**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identity Card No**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sex**  Male Female

**Marital Status** Single ( ) Married ( ) Other

**Home Address**

**Contact Number**: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of kin** | **Relationship** | **Address ( of next Kin )** | **Contact Number** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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**HEALTH DECLARATION**

Have you ever suffered any of the following conditions? (Please circle the right answer)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Description | YES | No | Description | YES | No |
| Psychiatric Illness | YES | No | Heart Diseases | YES | No |
| Epilepsy | YES | No | Thyroid Diseases | YES | No |
| Migraine | YES | No | Kidney Diseases | YES | No |
| Hysteria | YES | No | Gastric | YES | No |
| Allergic Rhinitis | YES | No | HIV /AIDS | YES | No |
| Asthma | YES | No | Cancer | YES | No |
| Tuberculosis (PTB) | YES | No | Venereal Diseases | YES | No |
| Hypertension (HPT) | YES | No | Leukemia | YES | No |
| Diabetes Mellitus (DM) | YES | No | Hepatitis | YES | No |

Please State (If any):

|  |  |
| --- | --- |
| Other Illness |  |
| Operation/Surgical |  |
| Allergy |  |
| Family Medical History |  |
| Disability/Handicap |  |

I hereby certify that the above information is true and complete, and agree that any misrepresentation or deliberate omissions of a material fact on this form may result in termination of my contract of service. I hereby grant the University of Technology Sarawak permission to share information contained in my Medical Examination Form when and where appropriate.

…………………………………………………………… ……………………………………………………….

Name: Date:

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**MEDICAL EXAMINATION**

(Physician is required to answer all questions with additional comment/s where necessary. Kindly note that the physician is responsible for the information, suggestion, and recommendation regarding the person’s health stated in this form)

Staff Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| WEIGHT |  | HEIGHT |  |
| BLOOD PRESSURE |  | PULSE |  |
| SKIN |  | COLOUR |  |
| EYE VISION TEST(RT) |  | EYE VISION (LT) |  |

Please describe fully any abnormalities of the following systems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Description | Normal | Abnormal | Comment |
| 1 | Skin |  |  |  |
| 2 | Head |  |  |  |
| 3 | Eyes |  |  |  |
| 4 | Ears |  |  |  |
| 5 | Nose |  |  |  |
| 6 | Mouth |  |  |  |
| 7 | Neck |  |  |  |
| 8 | Chest |  |  |  |
| 9 | Breast |  |  |  |
| 10 | Cardiovascular |  |  |  |
| 11 | Syncope |  |  |  |
| 12 | Chest Pain |  |  |  |
| 13 | Heart Murmur |  |  |  |
| 14 | Abdomen |  |  |  |
| 15 | Genitourinary |  |  |  |
| 16 | Extremities |  |  |  |
| 17 | Neurologic |  |  |  |

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**MEDICAL EXAMINATION**

**URINE TEST**

NAD WBC RBC GLUCOSE

**HEPATITIS TEST**

POSITIVE NEGATIVE

1. Is the staff now under treatment for any physical or emotional condition?

|  |  |
| --- | --- |
|  |  |

2. If yes, do you have any recommendations for the health care of this staff?

|  |  |
| --- | --- |
|  |  |

3. By history and physical examination, is this staff a carrier of any communicable disease?

|  |  |
| --- | --- |
|  |  |

**RESULT**

Medical Fit Unfit Limited Capability

……………………………………………………..

Physician’s Signature

Post and Qualification:

Date:

Note: In completing this form, particular attention should be paid to the following points:

a. X-ray of the Chest to rule out any tuberculosis or chronic pulmonary disease; where the film is entirely

normal, it needs not be forwarded, but if any abnormality is noted, the film should be sent with this report.

b. Kidneys-no evidence of renal lesion should be present.

c. Eyesight-severe errors of refraction should not be passed as these should only give trouble in later years.

d. Hearing-deafness should be considered a definite bar.

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