

Please submit the medical results online within 1 week at: go.gov.sg/mom-meportal

All parts in this form are to be completed by a Singapore-registered doctor. Any amendments must be endorsed by the doctor who completes this form. The foreign worker's Travel Document must be produced to the doctor for identification.

Part I Personal Particulars of Migrant Worker

Name: _____ Travel Document No.: _____ FIN: _____ Sex: *Male / Female

Height: _____ cm Weight: _____ kg Occupation: _____ Date of Birth: _____ Nationality/Citizenship: _____

Part II Medical History (To be declared and signed by the migrant worker)

	Yes	No	If yes, give brief details		Yes	No	If yes, give brief details
1 Mental illness	<input type="checkbox"/>	<input type="checkbox"/>		5 Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
2 Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		6 Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
3 Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>		7 Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
4 Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>		8 Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
				9 Operations	<input type="checkbox"/>	<input type="checkbox"/>	

I declare that all the information given above is true and correct. I hereby give my consent for a copy of this medical form after it is completed by the doctor to be released to the Ministry of Manpower, my employer, and also to the employment agent who assisted in my Work Permit application.

Signature of Migrant Worker _____

Date _____

Part III Please tick if any of the Examinations/Tests is Abnormal and give brief details separately. Tests marked with * are required for online submission.

Clinical Examinations	Abnormal	Other Tests	Abnormal
1 Cardiovascular System a Blood Pressure * Systolic: Diastolic: b Heart Disease c ECG (compulsory for male Thai workers & others above age 50, and in younger applicants where it is indicated, e.g. persons with cardiac murmurs or symptoms suggestive of Myocardial ischaemia) d Severe varicose veins	<input type="checkbox"/>	1 Chest X-ray – to be taken in Singapore * (Retain a copy of the radiological report in the event that employer requests for a copy): a Abnormal, no referral needed Remarks (including no active lesion): b Abnormal, cleared by NTBCC c Exempted due to pregnancy	<input type="checkbox"/>
2 Anaemia (if clinically anaemic, do HB: _____ g%)	<input type="checkbox"/>	2 Urine * a Urine Albumin b Urine Sugar c Pregnancy	<input type="checkbox"/>
3 Respiratory System	<input type="checkbox"/>	3 Syphilis screen/VDRL * a Positive (Currently infectious) b Positive (Treated/inactive)	<input type="checkbox"/>
4 Abdomen a Hernia b Enlarged Liver c Enlarged Spleen d Genito-Urinary System	<input type="checkbox"/>	4 Hearing (unable to hear ordinary conversation at 2m)	<input type="checkbox"/>
6 Locomotor/Neurological a Significant limb amputation or deformity b Limb movement and co-ordination c Significant spinal deformity d Other significant abnormalities (in relation to the Work required to be performed)	<input type="checkbox"/>	5 Vision (should be at least 6/12 in both eyes with or without glasses.) a Vision Acuity i) Right eye ii) Left eye b Colour Vision (for electricians & drivers only) * c Any organic eye disease, e.g. Trachoma	<input type="checkbox"/>
7 Endocrine disorders, e.g. thyrotoxicosis	<input type="checkbox"/>	6 Blood film for Malaria *	<input type="checkbox"/>
8 Mental state	<input type="checkbox"/>	7 HIV (AIDS) * Note: Test and blood film for Malaria must be done at labs approved by the Ministry of Health.	<input type="checkbox"/>

Part IV Vaccination given (please provide details, if any)

Type of vaccine	Brand of vaccine	Dose (1 st / 2 nd / 3 rd)

Part V Certification from the Doctor

I certify that I have examined the above-named migrant worker for the clinical examinations / tests in Part III and found that this person is *Fit / Unfit for employment in the above-stated occupation.

Name of Doctor (In BLOCK letters): _____ Signature of Doctor: _____
Clinic Address: _____ Date: _____

Telephone Number: _____