

**MEDICAL REPORT FOR FOREIGN WORKER
FOR EMPLOYMENT IN BRUNEI DARUSSALAM**
*(in accordance with The Infectious Diseases Order; Immigration Act and
Labour Act of the Statutes of Brunei Darussalam)*

photo

Accreditation no:

Ref. no.:

PART I: PERSONAL INFORMATION
(To be completed by the applicant)

1. FULL NAME:
(please underline surname)
2. SEX: MALE / FEMALE
3. DATE OF BIRTH:
4. PASSPORT NO:
5. TYPE OF JOB APPLIED:
6. ADDRESS IN COUNTRY OF ORIGIN:

.....
7. NAME OF EMPLOYER / RECRUITING AGENCY:
8. FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY:

.....

PART II: MEDICAL HISTORY
(To be completed by the examining physician)

Has the worker ever suffered from or experienced or received treatment for the following diseases and conditions? If 'YES', please indicate dates of detection and treatment received.

- 1 HIV / AIDS *
- 2 TUBERCULOSIS *
- 3 EPILEPSY *
- 4 LEPROSY*
- 5 SEXUALLY TRANSMITTED INFECTIONS *
- 6 PSYCHIATRIC ILLNESS *
- 7 HEPATITIS B *
- 8 HEPATITIS C *
- 9 DRUG USE *
- 10 DIABETES MELLITUS **
- 11 HYPERTENSION **
- 12 CANCER **
- 13 BRONCHIAL ASTHMA **
- 14 HEART DISEASE **
- 15 KIDNEY DISEASE **
- 16 HEARING PROBLEM **
- 17 VISION PROBLEM **
- 18 PEPTIC ULCER **
- 19 MALARIA
- 20 OTHERS

	YES	NO	DATE/TREATMENT
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

* To be considered unfit if answered 'yes' to any of the items

**Fitness is up to the discretion of the attending physician; must indicate severity, complications and medications currently taken by the applicant

PART III: PHYSICAL EXAMINATION AND INVESTIGATIONS
(To be completed by the examining physician)

Section A: General Physical Examination

1. Height: _____ cm 2. Weight: _____ kg 3. Pulse: _____ /min
 4. Blood pressure : _____ mmHg (Systolic/Diastolic)

	Present	Absent
5 Chronic skin rash/sores on hands		
6 Deformities of limbs		
7 Anaemia		
8 Jaundice		
9 Lymph node enlargement		
10 Hearing impairment		
11 Vision test		
Unaided		
Aided		
Colour blindness		

Section B: Systemic Examination

	Normal	Abnormal
1 Cardiovascular System		
1.1. Heart Size		
1.2. Heart Sounds		
1.3. Other Findings _____		

2 Respiratory System		
2.1. Breath Sounds		
2.2. Other Findings _____		

3 Gastrointestinal System		
3.1. Liver		
3.2. Spleen		
3.3. Kidney		

3.4. Is there any abnormal swelling? (YES/NO) Indicate if 'YES'

3.5. Rectal Examination

	Normal	Abnormal
4 Central Nervous System		
4.1. General Mental Status		
4.2. Speech		
4.3. Cognitive Function		
4.4. Motor power		
4.5. Sensory		
4.6. Reflexes		

	Yes	No
5 Genitourinary System		
5.1. Discharge		
5.2. Sores / Ulcers		

Section C: Laboratory results and X-ray findings

	Negative	Positive
1. Blood		
1.1. HIV Antibody #		
1.2. HBsAg #		
1.3. HCV #		
1.4. VDRL/ TPHA #		
1.5. Malaria Parasite		

If positive for malaria, give appropriate treatment and then repeat 1.5

Date when blood test for malaria parasite is found negative after treatment: _____

2. Urine Examination

2.1. Colour: _____
2.2. Specific Gravity: _____

2.3. Sugar
2.4. Albumin
2.5. Microscopic Examination: _____
2.6. Others: _____

2.7. Opiates #
2.8. Cannabis #
2.9. Methphetamines #
2.10. Benzodiazepines #
2.11. Pregnancy #

Negative	Positive

Normal	Abnormal

3. Chest X-Ray Report

(valid for 6 months) - **UNFIT IF ANY ABNORMALITY IN THE LUNG FIELDS are present)**

4. Stool examination # [for those handling food]

Salmonella Typhi
V.Cholera
V.Parahaemolyticus
Shigella
E.Histolytica
Other enteropathogens (please state)

Negative	Positive

If positive for any of the above, give appropriate treatment and then repeat stool examination

Date when stool examination is found negative for all of the above after treatment: _____

5. Sputum AFB (if indicated)

Negative Positive

6. ECG (if indicated)

Normal Abnormal

7. Slit skin smear (if indicated)

Negative Positive

To be considered unfit if found positive/ abnormal

PART IV: VACCINATIONS GIVEN (IF APPLICABLE)

	Vaccine	Batch no.	Given by
1. Typhoid/ Paratyphoid	_____	_____	_____
2. Tetanus	_____	_____	_____
3. Hepatitis B	_____	_____	_____
4. Others (Please state)	_____	_____	_____

PART V: CERTIFICATION BY EXAMINING PHYSICIAN

I HAVE EXAMINED THE ABOVENAMED APPLICANT AND FOUND THAT HE / SHE IS FREE FROM THE FOLLOWING DISEASES:

	YES	NO
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
MALARIA	<input type="checkbox"/>	<input type="checkbox"/>
LEPROSY	<input type="checkbox"/>	<input type="checkbox"/>
SEXUALLY TRANSMITTED INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS B	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS C	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATES / CANNABIS / METHAMPHETAMINES / BENZODIAZEPINES.

SHE IS / IS NOT PREGNANT (IF APPLICABLE).

HE / SHE HAS / HAS NOT BEEN GIVEN THE APPROPRIATE VACCINATIONS (IF APPLICABLE).

HE / SHE IS **FIT / UNFIT** TO BE EMPLOYED IN THE JOB THAT HE / SHE IS APPLYING FOR.

I THEREFORE RECOMMEND THAT HE / SHE BE **CONSIDERED / NOT CONSIDERED** FOR EMPLOYMENT.
[IF NOT CONSIDERED FOR EMPLOYMENT PLEASE STATE THE REASON(S) BELOW]

SIGNATURE

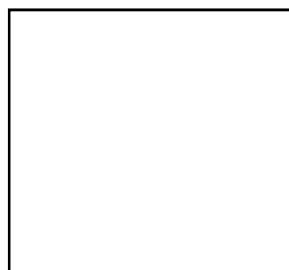
DATE

NAME OF CERTIFYING PHYSICIAN: _____

ADDRESS OF PHYSICIAN: _____

QUALIFICATIONS: _____

OFFICIAL STAMP



(TO BE RETAINED BY THE EXAMINING PHYSICIAN)

**FOR OFFICIAL USE ONLY BY THE EMBASSY/HIGH COMMISSION/CONSULATE
OR REPRESENTATIVE OFFICE OF BRUNEI DARUSSALAM**

Accreditation no:

Ref.no:

1. FULL NAME:
(please underline surname)

2. SEX: MALE / FEMALE 3. DATE OF BIRTH: 4. PASSPORT NO:

5. TYPE OF JOB APPLIED:

6. ADDRESS IN COUNTRY OF ORIGIN:

.....

7. NAME OF EMPLOYER / RECRUITING AGENCY:

.....

8. FULL ADDRESS OF EMPLOYER / RECRUTING AGENCY:

.....

I HAVE PERUSED THE ABOVE APPLICANT'S PRE-EMPLOYMENT MEDICAL DOCUMENTS AND FOUND
THAT THE RECORDS ARE / ARE NOT IN ORDER AND HEREBY ISSUE / NOT ISSUE AN EMPLOYMENT ENTRY
VISA.

VISA NUMBER ISSUED: _____

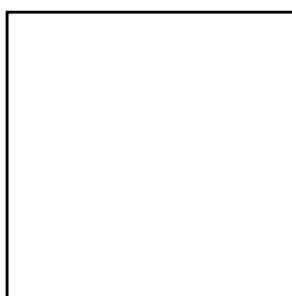
SIGNATURE

DATE

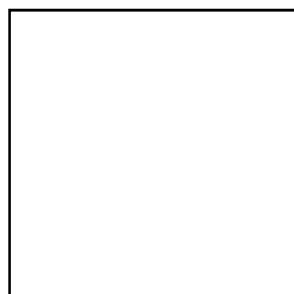
NAME OF OFFICIAL: _____

DESIGNATION: _____

APPLICANT'S PHOTO



OFFICIAL STAMP



(TO BE RETAINED AT THE ABOVE OFFICE FOR REFERENCE)



MINISTRY OF HEALTH BRUNEI DARUSSALAM

MEDICAL CERTIFICATE FOR FOREIGN WORKER

(Please attach all results of investigations, X-ray and radiologist report)

Accreditation no:.....

Ref.no:.....

1. FULL NAME:
(please underline surname)
2. SEX: MALE / FEMALE 3. DATE OF BIRTH : 4. PASSPORT NO:.....
5. TYPE OF JOB APPLIED :
6. FULL ADDRESS IN COUNTRY OF ORIGIN :
7. NAME AND FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY.....

I HAVE EXAMINED THE ABOVE NAMED APPLICANT AND FOUND THAT HE / SHE IS FREE FROM THE FOLLOWING DISEASES:

HIV / AIDS
TUBERCULOSIS
MALARIA
LEPROSY
SEXUALLY TRANSMITTED INFECTIONS
HEPATITIS B
HEPATITIS C
EPILEPSY
PSYCHIATRIC ILLNESS

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATES / CANNABIS / AMPHETAMINES / BENZODIAZEPINES

SHE IS NOT PREGNANT (IF APPLICABLE)

HE / SHE HAS BEEN GIVEN THE APPROPRIATE VACCINATIONS (PLEASE STATE IF GIVEN)

HE / SHE IS **FIT / UNFIT** TO BE EMPLOYED IN THE JOB THAT HE / SHE IS APPLYING FOR.
I THEREFORE RECOMMEND THAT HE / SHE BE **CONSIDERED / NOT CONSIDERED** FOR EMPLOYMENT.

SIGNATURE

DATE

NAME OF CERTIFYING PHYSICIAN: _____

ADDRESS OF PHYSICIAN: _____

QUALIFICATIONS: _____ TEL.NO: _____ FAX NO: _____

Official stamp

Photo

VALID ONLY FOR 180 DAYS FROM THE DATE OF ISSUE

