Appendix II - HEALTH CERTIFICATE

Hospital's Mark

ITEMS REQUIRED FOR HEALTH CERTIFICATE (Type I)
(Country Name, Hospital's Name, Address, Tel No., F No.)

Date of Examination ____/____/____ (D) (M) (Y)

Personal Information

Name :		Sex :	☐Male ☐Female
ID No. :		Age :	
Date of Birth : / /		Marital Status :	☐Married ☐Single
Passport No. :		Nationality :	
County (Staying) :		Phone No. :	
Passport No. :		Nationality :	

2"Photo

Medical History

Have you ever had any of the following diseases/illnesses：

A. Heart disease	☐Yes	☐No	I. Malaria	☐Yes	☐No
B. Hypertension	☐Yes	☐No	a.☐ *Plasmodium vivax*		
C. Lung disease	☐Yes	☐No	b.☐ *Plasmodium ovale*		
D. Asthma	☐Yes	☐No	c.☐ *Plasmodium malariae*		
E. Liver disease	☐Yes	☐No	d.☐ *Plasmodium falciparum*		
F. Diabetes	☐Yes	☐No	J. Tuberculosis	☐Yes	☐No
G. Kidney disease	☐Yes	☐No	K. Dengue Fever	☐Yes	☐No
H. Epilepsy	☐Yes	☐No	L. Others		

(PHYSICAL EXAMINATION)

A. Height	: _____ cms		J Lungs	☐Normal	☐Abnormal
B. Weight	: _____ kgs		K Liver	☐Normal	☐Abnormal
C. Blood Pressure	: ____ / ____ mmHg		L. Spleen	☐Normal	☐Abnormal
D. Pulse	: _____ times/min		M. Thyroid gland	☐Normal	☐Abnormal
E. Vision	: Right ____ Left ____		N. Lymph nodes	☐Normal	☐Abnormal
F. Skin	☐Normal	☐Abnormal	O. External genitalia	☐Normal	☐Abnormal
G. Ears	☐Normal	☐Abnormal	P. Hernia	☐Normal	☐Abnormal
H. Eyes	☐Normal	☐Abnormal	Q. Locomotor	☐Normal	☐Abnormal
I. Heart	☐Normal	☐Abnormal	R. Mental condition	☐Normal	☐Abnormal

S. Others_____ _____(If abnormal, specify disease.)

LABORATORY EXAMINATIONS

A.Serological Test for HIV：□(Positive)□(Negative)□(Indeterminate)
a.Screening Test： □EIA □Serodia □(Others)_____
b.Confirmatory Test：□Western Blot □(Others)_____

B.Chest X-Ray for Tuberculosis：
□(Normal) □(Abnormal)_____
※（**Standard Film Only**）

C.(Serological Test for Syphilis)：□(Positive)□(Negative)
a.□RPR b.□VDRL c.□TPHA d.□(Other)

Remark：This form is for **Group B alien workers**.

Conclusion：The above medical report of Mr./Mrs./Ms.____,He/She □passed □failed the checkup.

(Medical Technologist in charge) _____ (Name Signature)

(Physician in charge) _____ (Name Signature)

(Superintendent) _____ (Name Signature)