

MEDICAL REPORT نموذج تقرير طبي

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			LABORATORY INVESTIGATION		
TYPE OF MEDICAL EXAMINATION			TYPE OF LABORATORY INVESTIGATION		
EYE	VISION	R.EYE	[URINE]	-SUGAR	
		L.EYE		- ALBUMIN	
OTHER		R.EYE	- BILHARZIASIS		
		L.EYE	- OTHER		
EAR		R.EAR	[STOOL]	- HELMINTHES	
		L.EAR	- SALMONELLA/SHIGELLA		
CHEST X - RAY PULMONARY TUBERCULOSIS				- V.CHOLERA	
[SYSTEMIC EXAMINATION]				- OTHER	
	BLOOD PRESSURE		[BLOOD]	- HAEMOGLOBIN	
	HEART			- MALARIA FILM	
	LUNGS			- OTHERS	
	ABDOMEN		[SEROLOGY]	- HIV TEST(FROM A PROVINCIAL LAB.)	
[OTHERS]	* HERNIA			- F.B.S.	
	* VARICOSE VAINS			- HBsAG/ANTI HCV	
EXTREMITIES				- L.F.T.	
SKIN				- CREATININE	
[VENERAL DISEASES]				- UREA	
- CLINICAL					
- LAB					
	VDRL				
	TPHA				
			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)	DEPARTMENT OF HEALTH (FEDERAL OR PROVINCIAL) (2)
AUTHORIZED SIGNATURE	STAMP OR SEAL OF THE PROVINCIAL LICENSING AUTHORITY (college of physicians)