MEDICAL REPORT

PHOTO	NAME:
	PASSPORT NO:
	POSITION APPLIED FOR:

PAST MEDICAL HISTORY

A) Venereal Disease .....

B) Any Significant Illness .....

LEFT EAR:	
RIGHT EAR:	
LEFT EYE:	
RIGHT EYE:	
SURGERY:	
CXR:	
LIVER	a) LFT:
	b) Vaccines:
BILHARZIA:	
TB:	
MALARIA:	
DM (URINE ANALYSIS):	
BP:	
SEROLOGY VDRL / TPHA:	
HIV ANTIBODY:	
PREGNANCY (if applicable):	
ANTI HBe:	
ANTI HBs:	
ANTI HBc:	TOTAL:
	IgG:
	IgM:
HBcAg:	
HCAb:	
OTHER DISEASE:	
The above person is :	Fit for employment NOT fit for employment
Physician:	
Address:	
Signature:	Dated:

Official Seal of Physician / Practice or Hospital.