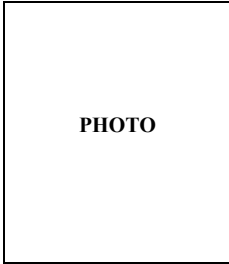




MEDICAL REPORT

رقب و صحت المملكة العربية السعودية



NAME: \_\_\_\_\_

NATIONALITY:	SEX:	AGE:	MARITAL STATUS:
PASSPORT NO:	ISSUE PLACE:	ISSUE DATE:	
POSITION APPLIED FOR:			

DEAR SIR / MADAM  
PLEASE, ARRANGE TO EXAMINE THE ABOVE MENTIONED CANDIDATE AS TO HIS/HER FITNESS FOR THE ABOVE MENTIONED POSITION.

DATE \_\_\_/\_\_\_/\_\_\_ RECRUITMENT 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		NEGATIVE\NORMAL	POSITIVE\ABNORMAL	TYPE OF LABORATORY INVESTIGATION	NEGATIVE\NORMAL	POSITIVE\ABNORMAL
VISION	R. EYE			(URINE)		
	L. EYE				- SUGAR	
EYE	OTHER				- ALBUMIN	
	R. EYE				- BILHARZIASIS	
EAR	L. EYE				- OTHER	
	R. EAR			(STOOL)		
CHEST X - RAY	L. EAR				- HELMINTHES	
					- SALMONELLA/SHIGELLA	
PULMONARY TUBERCULOSIS (SYSTEMIC EXAMINATION)					- V.CHOLERA	
					- OTHER	
BLOOD PRESSURE				(BLOOD)		
	HEART				- HEMOGLOBIN	
LUNGS					- MALARIA FILM	
	ABDOMEN				- OTHERS	
(OTHERS)				(SEROLOGY)		
	*HERNIA				- HIV TEST	
EXTREMITIES	*VARICOSE VEINS					
					- F. B. S.	
SKIN					- HBSAG/ANTI HCV	
	(VENEREAL DISEASES)				- L. F. T.	
- CLINICAL					- CREATININE	
	- LAB				- UREA	
VDRL						
	TPHA			PREGNANCY TEST		

CONFIRM IF THE APPLICATION HAS ONE OF THE FOLLOWING: NO YES

COMMUNICABLE DISEASES		
MENTAL DISORDER		
MENTAL RETARDATION		
PHYSICAL DISORDERS		
HANDICAP		
PARALYSIS		
BLINDNESS		
HEARING DISORDER		
SPEECH DISORDER		

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. IN THE EVENT OF AN ABNORMAL/POSITIVE RESULT, A TYPEWRITTEN LETTER SIGNED BY THE PHYSICIAN STATING THE CONDITION AND ANY TREATMENT IMPLEMENTED. THIS LETTER SHOULD ALSO INDICATE WHETHER THIS CONDITION OR TREATMENT WILL HAVE ANY EFFECT ON THE APPLICANT'S WORK.

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 MEDICINE. AUTHORIZED SIGNATURE : _____ (1)	DEPARTMENT OF HEALTH (2)
STAMP OR SEAL OF THE STATE AUTHORITY (COLLEGE OF PHYSICIANS)	