



**SECTION 1**

(PART B) – Please tick (✓) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illness.

\* Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If yes, Please state
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental Illness					
4. Fits, Stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart and Vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug Addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other Illnesses					

Current medication (Long Term)

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others					

I hereby certify that the information given is true. I understand that my application will be rejected if there is any false information given.

.....  
Date

.....  
Signature of candidate

## SECTION 2 – PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE : _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____ / min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST : NORMAL / ABNORMAL

2. GENERAL EXAMINATIONS			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMATIC EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFIES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

**SECTION 3 – INVESTIGATIONS**

<b>URINE TEST</b>		
<b>ITEM</b>	<b>DATE TAKEN</b>	<b>RESULT</b>
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

<b>BLOOD TEST</b>		
<b>ITEM</b>	<b>DATE TAKEN</b>	<b>RESULT</b>
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

<b>CHEST X-RAY INFORMATION</b>	
<b>CHEST X-RAY NO.</b>	
<b>DATE TAKEN</b>	
<b>PLACE TAKEN</b>	
<b>REPORT</b>	

**SECTION 4 – CERTIFICATION BY THE EXAMINING DOCTOR**

Please tick (✓) in the appropriate box

I certify that I have on this date \_\_\_\_\_ examined  
Mr / Ms \_\_\_\_\_ Passport No. \_\_\_\_\_ and  
found him / her :-

**IN GOOD HEALTH**

**HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**UNDERGOING TREATMENT FOR: (Please State)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Doctor : \_\_\_\_\_  
Name of Doctor : \_\_\_\_\_  
Qualification : \_\_\_\_\_  
Hospital / Clinic Registration : \_\_\_\_\_  
Number : \_\_\_\_\_  
Official stamp : \_\_\_\_\_

Remarks By University / College Official: