

**FOR OFFICIAL USE ONLY BY THE EMBASSY/HIGH COMMISSION/CONSULATE
OR REPRESENTATIVE OFFICE OF BRUNEI DARUSSALAM**

Accreditation no:

Ref.no:

1. FULL NAME:
(please underline surname)
2. SEX: MALE / FEMALE 3. DATE OF BIRTH : 4. PASSPORT NO:.....
5. TYPE OF JOB APPLIED :
6. ADDRESS IN COUNTRY OF ORIGIN :
7. NAME OF EMPLOYER / RECRUITING AGENCY :
8. FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY :

I HAVE PERUSED THE ABOVE APPLICANT'S PRE-EMPLOYMENT MEDICAL DOCUMENTS
AND FOUND THAT THE RECORDS ARE / ARE NOT IN ORDER AND HEREBY:

- ISSUE
- NOT ISSUE

AN EMPLOYMENT ENTRY VISA.

VISA NUMBER ISSUED: _____

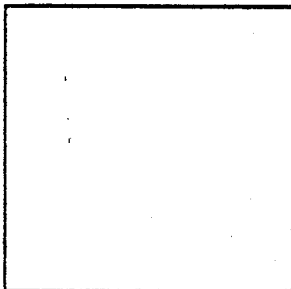
SIGNATURE

DATE

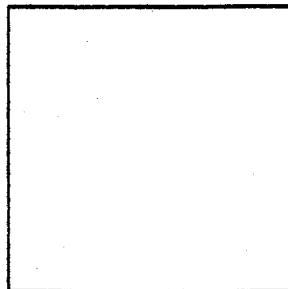
NAME OF OFFICIAL: _____

DESIGNATION: _____

APPLICANT'S PHOTO



OFFICIAL STAMP



(TO BE RETAINED AT THE ABOVE OFFICE FOR FUTURE REFERENCE)

PART III : PHYSICAL EXAMINATION AND INVESTIGATIONS
(To be completed by the attending physician)

Section A : General Physical Examination

1. Height : _____ cm 2. Weight : _____ kg 3. Pulse : _____ /min
4. Blood pressure : _____ mmHg (Systolic /Diastolic)

- 5 Chronic skin rash/sores on hands
 6 Anaesthetic skin patch
 7 Deformities of limbs
 8 Anaemia
 9 Jaundice
 10 Lymph node enlargement
- 11 Hearing impairment
- 12 Vision test

PRESENT	ABSENT
RIGHT	LEFT

- Unaided
 Aided
 Colour blindness

PRESENT	ABSENT

Section B : Systemic Examination

- 1 Cardiovascular System
 1.1. Heart Size
 1.2. Heart Sounds
 1.3. Other Findings _____
- 2 Respiratory System
 2.1. "Breath Sounds"
 2.2. Other Findings _____
- 3 Gastrointestinal System
 3.1. Liver
 3.2. Spleen
 3.3. Kidney
 3.4. Is there any abnormal swelling? YES / NO Indicate if "YES"

Normal	Abnormal

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3.5. Rectal Examination

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- 4 Central Nervous System
 4.1. General Mental Status
 4.2. Speech
 4.3. Cognitive Function
 4.4. Motor power
 4.5. Sensory
 4.6. Reflexes

Normal	Abnormal

- 5 Genitourinary System
 5.1. Discharge
 5.2. Sores / Ulcers

YES	NO

Section C : Laboratory Results and X-ray Findings

	Negative	Positive
1 Blood		
1.1. HIV Antibody #		
1.2. HbsAg #		
1.3. VDRL /TPHA #		
1.4. Malaria Parasite		

If positive for malaria, give appropriate treatment and then repeat 1.4
 Date when blood test for malaria parasite is found negative after treatment : _____

2. Urine Examination

 2.1. Urine Examination - Colour : _____ Specific Gravity : _____

	Negative	Positive
Sugar		
Albumin		

Microscopic Examination : _____
 Others: _____

2.2. Opiates / Cannabis #		
2.3. Pregnancy #		

3 Chest X-Ray Report (Large film)	Normal	Abnormal
(valid for 6 months- UNFIT IF ANY ABNORMALITY IN THE LUNG FIELDS are present)		

4 Stool examination # [for those handling food]	Negative	Positive
<i>Salmonella Typhii</i>		
<i>V.Cholera</i>		
<i>V.Parahaemolyticus</i>		
<i>Shigella</i>		
<i>E.Histolytica</i>		
<i>Other enteropathogens (please state)</i>		

If positive for any of the above, give appropriate treatment and then repeat stool exam
 Date when stool exam is found negative for all of the above after treatment : _____

5 Sputum AFB (if indicated)	POSITIVE	NEGATIVE
6 ECG (if indicated)	NORMAL	ABNORMAL
7 Slit skin smear (if indicated)	POSITIVE	NEGATIVE

To be considered unfit if found positive/ abnormal

PART IV: VACCINATIONS GIVEN (IF APPLICABLE)

	Vaccine	Batch no.	Given by
1. Typhoid/Paratyphoid	_____	_____	_____
2. Tetanus	_____	_____	_____
3. Hepatitis B	_____	_____	_____
4. Others (Please state)	_____	_____	_____

PART V: CERTIFICATION BY PHYSICIAN

I HAVE EXAMINED THE ABOVENAMED APPLICANT AND FOUND THAT HE / SHE IS FREE FROM THE FOLLOWING DISEASES:

	YES	NO
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
MALARIA	<input type="checkbox"/>	<input type="checkbox"/>
LEPROSY	<input type="checkbox"/>	<input type="checkbox"/>
SEXUALLY TRANSMITTED INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS B	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATE / CANNABIS.

SHE IS / IS NOT PREGNANT (IF APPLICABLE)

HE / SHE HAS / HAS NOT BEEN GIVEN THE APPROPRIATE VACCINATIONS (IF APPLICABLE)

HE / SHE IS FIT / UNFIT TO BE EMPLOYED IN THE JOB THAT HE / SHE IS APPLYING FOR

I THEREFORE RECOMMEND THAT HE / SHE BE CONSIDERED / NOT CONSIDERED FOR EMPLOYMENT (IF NOT CONSIDERED FOR EMPLOYMENT PLEASE STATE THE REASON(S) BELOW)

SIGNATURE

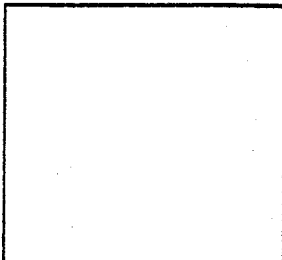
DATE

NAME OF CERTIFYING PHYSICIAN: _____

ADDRESS OF PHYSICIAN: _____

QUALIFICATIONS: _____

OFFICIAL STAMP



(TO BE RETAINED BY THE EXAMINING PHYSICIAN)

MINISTRY OF HEALTH BRUNEI DARUSSALAM
MEDICAL CERTIFICATE FOR FOREIGN WORKER
(Please attach all results of investigations, X-Ray and radiologist report)

Accreditation no:

Ref.no:

1. FULL NAME:
(please underline surname)
2. SEX: MALE / FEMALE 3. DATE OF BIRTH: 4. PASSPORT NO:
5. TYPE OF JOB APPLIED :
6. FULL ADDRESS IN COUNTRY OF ORIGIN :
7. NAME AND FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY

I HAVE EXAMINED THE ABOVE NAMED APPLICANT AND FOUND THAT HE / SHE IS FREE FROM THE FOLLOWING DISEASES:

- HIV / AIDS
- TUBERCULOSIS
- MALARIA
- LEPROSY
- SEXUALLY TRANSMITTED INFECTIONS
- HEPATITIS B
- EPILEPSY
- PSYCHIATRIC ILLNESS

AND HIS / HER URINE IS FOUND NOT TO CONTAIN OPIATE / CANNABIS
SHE IS NOT PREGNANT (IF APPLICABLE)
HE / SHE HAS BEEN GIVEN THE APPROPRIATE VACCINATIONS (PLEASE STATE IF GIVEN)

HE / SHE IS FIT TO BE EMPLOYED IN THE JOB THAT HE / SHE IS APPLYING FOR
I THEREFORE RECOMMEND THAT HE / SHE BE CONSIDERED FOR EMPLOYMENT

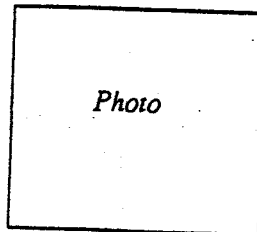
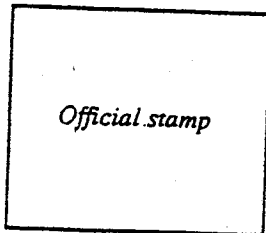
SIGNATURE

DATE

NAME OF CERTIFYING PHYSICIAN: _____

ADDRESS OF PHYSICIAN: _____

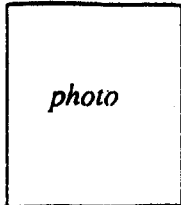
QUALIFICATIONS: _____ TEL.NO: _____ FAX NO: _____



(TO BE RETAINED BY THE WORKER)
VALID ONLY FOR THREE MONTHS FROM THE DATE OF ISSUE

MEDICAL REPORT FOR FOREIGN WORKER FOR EMPLOYMENT IN BRUNEI DARUSSALAM

(in accordance with the Quarantine and Prevention of Diseases Act, Section 3(6), Chapter 47, 1934; Immigration Act, Sections 8 & 29 Chapter 17; Labor Act, Sections 23 & 50, Chapter 93 of the Statutes of Brunei Darussalam)



Accreditation no:

Ref. no.:

Part I : Personal Information (This part is to be completed by the applicant)

1. FULL NAME:
(please underline surname)
2. SEX: MALE / FEMALE 3. DATE OF BIRTH : 4. PASSPORT NO:.....
5. TYPE OF JOB APPLIED :
6. ADDRESS IN COUNTRY OF ORIGIN :
7. NAME OF EMPLOYER / RECRUITING AGENCY :
8. FULL ADDRESS OF EMPLOYER / RECRUITING AGENCY:

PART II : MEDICAL HISTORY

(To be completed by the attending physician)

Has the worker ever suffered from or experienced or received treatment for the following diseases and conditions? If "YES", please indicate dates of detection and treatment received.

	YES	NO	DATE/TREATMENT
1 HIV / AIDS *			
2 TUBERCULOSIS *			
3 EPILEPSY *			
4 LEPROSY*			
5 SEXUALLY TRANSMITTED INFECTIONS *			
6 PSYCHIATRIC ILLNESS *			
7 HEPATITIS B*			
8 DRUG USE *			
9 DIABETES MELLITUS **			
10 HYPERTENSION **			
11 CANCER **			
12 BRONCHIAL ASTHMA **			
13 HEART DISEASE **			
14 KIDNEY DISEASE **			
15 HEARING PROBLEM**			
16 VISION PROBLEM**			
17 PEPTIC ULCER**			
18 MALARIA			
19 OTHERS (Please state)			

* To be considered unfit if answered 'yes' to any of the item
 ** Fitness up to the discretion of the attending Physician; must indicate severity, complications and medications currently taken by the applicant