

## MEDICAL REPORT

<b>PHOTO</b>	<b>NAME:</b>
	<b>PASSPORT NO:</b>
	<b>POSITION APPLIED FOR:</b>

## 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 <u>NOT</u> fit for employment	
Physician:	
Address:	
Signature:	Dated:

Official Seal of Physician / Practice or Hospital.