

PART A: APPLICANT'S DETAILS (to be completed by applicant)

Name:	<i>(In capital letters according to IC/Passport)</i>		
Address			
Position applied for:			
IC/Passport No.:		Nationality:	
Date of Birth:		Age:	
Telephone No.:		Gender:	

PART B: HEALTH DECLARATION OF APPLICANT (to be completed by applicant)

1.0	HAVE YOU (HAD):	YES	NO	IF YES, PROVIDE DETAILS AND DATE
1.1	been admitted to hospital for whatever reason in the past?	()	()	_____
1.2	asthma or wheezing attack?	()	()	_____
1.3	tuberculosis, pneumonia or other lung problems?	()	()	_____
1.4	any abdominal problems ie. hernia, duodenal ulcer, haemorrhoids, blood in stool or vomit?	()	()	_____
1.5	high blood pressure?	()	()	_____
1.6	chest pain, rheumatic fever or any other heart problems?	()	()	_____
1.7	kidney or bladder problems – kidney stones, blood in urine, urine infections?	()	()	_____
1.8	gynaecological problems?	()	()	_____
1.9	sexually transmitted disease?	()	()	_____
1.10	epilepsy, fainting spells, convulsions?	()	()	_____
1.11	mental illness, depression, suicide attempts?	()	()	_____
1.12	eye injury or disease?	()	()	_____
1.13	ear, nose or throat problems?	()	()	_____
1.14	diabetes, thyroid or other gland disorder?	()	()	_____
1.15	arthritis, joint or back problems?	()	()	_____
1.16	hepatitis or jaundice, typhoid fever, cholera or other tropical disease?	()	()	_____
1.17	Any other medical condition not mentioned above?	()	()	_____

2.0 DO YOU:	YES	NO	IF YES, PROVIDE DETAILS AND DATE
2.1 Smoke? If yes, how much?	()	()	_____
2.2 Use alcohol or drugs? If yes, how much?	()	()	_____ _____
3.0 ARE YOU ALLERGIC TO ANY MEDICATIONS, FOOD, PLASTER OR ANY OTHER SUBSTANCE?	()	()	_____ _____
4.0 FAMILY HISTORY			
4.1 Diabetes	()	()	_____ _____
4.2 Hypertension (High Blood Pressure)	()	()	_____ _____
4.3 Heart Disease/Problem	()	()	_____ _____
4.4 Asthma	()	()	_____ _____
4.5 Tuberculosis (TB)	()	()	_____ _____
4.6 Mental sickness (N/A)	(N/A)	(N/A)	Not Applicable
4.7 Fits	()	()	_____ _____
4.8 Other inherited medical problems	()	()	_____ _____
5.0 OTHER INFORMATION			
5.1 Do you give permission to your medical records being examined by the present Doctor (Medical Officer)?	()	()	_____ _____

I hereby declare that the information given is correct to the best of my knowledge. I give consent to the use of this information by the examining doctor to determine my fitness for employment. I realize that a false statement can disqualify me from employment.

Signature of applicant: _____ Verified by examining doctor: _____

Date: _____ Date: _____

To: The Human Resources Department
Monash University Malaysia

Dear Sir/Madam,

This is to certify that I, _____ have
examined _____
(examining doctor's name)

_____, IC/Passport No.

(applicant's name)

on _____.

In my opinion, he / she is physically fit and suitable for employment

Remarks: _____

OR

Suffering from _____ but fit for service

Remarks: _____

OR

Unfit for service due to _____

Remarks: _____

Further comments:

Signature of examining doctor: _____

Doctor's Name: _____

Hospital or Clinic Stamp: _____

Date: _____