



MEDICAL REPORT نموذج تقرير طبي

PHOTO	NAME _____				
	NATIONALITY _____	SEX _____	AGE _____	MARITAL STATUS _____	
	PASSPORT NO. _____		PLACE & DATE OF ISSUE _____		
	POSITION APPLIED FOR _____				

DEAR SIR, MADAM

PLEASE , ARRANGE TO EXAMINE THE ABOVE MENTIONED CANDIDATE WHETHER HE/SHE IS FIT FOR THE ABOVE MENTIONED POSITION .

DATE ___/___/___ RECRUTEMENT 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
EYE	VISION	R.EYE		[URINE]	-SUGAR		
		L.EYE			- ALBUMIN		
	OTHER	R.EYE			- BILHARZIASIS		
EAR		L.EYE			- OTHER		
		R.EAR		[STOOL]	- HELMINTHES		
		L.EAR			- SALMONELLA/SHIGELLA		
CHEST X - RAY PULMONARY TUBERCULOSIS					- V. CHOLERA		
[SYSTEMIC EXAMINATION]				[BLOOD]	- OTHER		
	BLOOD PRESSURE				- HAEMOGLOBIN		
	HEART				- MALARIA FILM		
	LUNGS				- OTHERS		
	ABDOMEN			[SEROLOGY]	- HIV TEST (FROM A PROVINCIAL LAB.)		
[OTHERS]	* HERNIA				- F.B.S.		
	* VARICOSE VAINS				- HBsAG/ANTI HCV		
EXTREMITIES					- L.F.T.		
SKIN					- CREATININE		
[VENERAL DISEASES]					- UREA		
	- CLINICAL						
	- LAB						
	VDRL						
	TPHA			PREGNANCY TEST			

CONFIRM IF THE APPLICANT HAS ONE OF THE FOLLOWING:

	NO	YES
COMMUNICABLE DISEASES		
MENTAL DISORDER		
MENTAL RETARDATION		
PHYSICAL DISORDERS		
HANDICAP		
PARALYSIS		
BLINDNESS		
DEAFNESS		
DUMBNESS		

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. A CHECK MARK (✓), ONLY, MUST BE INSERTED IN THE NEGATIVE \NORMAL SECTIONS ABOVE. IN THE EVENT OF ANY POSITIVE TEST RESULTS A TYPED & SIGNED NOTE FROM THE DOCTOR STATING IF THIS IS A COMMUNICABLE OR NON COMMUNICABLE DISEASE AND TO ADVISE US OF TREATMENT UNDER TAKEN AND IF IT HAS ANY EFFECT ON THE APPLICANT'S WORK.

SUBMIT TO THE CONSULAR SECTION ORIGINALS AND COPIES OF THIS REPORT AND THE TESTS RESULTS . DO NOT SUBMIT X-RAY'S AS THOSE MUST BE PRESENTED TO THE HEALTH AUTHORITIES IN SAUDI ARABIA ALONGWITH ONE CLEAR COPY OF THIS REPORT AND ALL TEST RESULTS.

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 MEDECINE . (1) AUTHORIZED SIGNATURE _____	DEPARTMENT OF HEALTH (FEDERAL OR PROVINCIAL) (2) STAMP OR SEAL OF THE PROVINCIAL LICENSING AUTHORITY (college of physicians)
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INSTRUCTIONS TO THE Dr.doing the tests

- 1- Pls make sure to ask for the HBsAG & ANTI HCV
- 2- Pls use a check mark  only to put whether it is negative or positive near each test, explanations must be on a separate note only not on the medical report the consular section will reject it. Pls do not put any numbers, or write see attached.
- 3- IF THE TEST RESULT DOES NOT SHOW A NEGATIVE SIGN AND GIVES STANDARD COMMENTS YOU ARE REQUESTED TO HAVE EITHER THE LAB. OR THE DOCTOR INDICATE THE RESULT OF NEGATIVE OR POSITIVE ON THE TEST REESULT IT SELF & MUST BE SIGNED. IN CASE OF POSTIVE A FULL TYPED EXPLANTION IS REQUIRED.
- 4- The medical report must be stamped by the college of physcians to be accepted by the Saudi consular Section, pls give the applicant the address and phone number of the college of physcians that you are registered with.
- 5- Pls give the applicant copies of all the test results it is a requirement Make sure it includes Hep B, Hep c, Hiv & VDRL