

## MEDICAL REPORT

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РНОТО		NAME:										
		NATIONALITY: S				SEX: AGE: MARITAL				STATUS:		
		PASSPORT NO: ISSUE PLACE:						ISSUE DATE				
		POSITION APPLIED FOR:										
		DEAR SIR / MADAM PLEASE, ARRANGE TO EXAMINE THE ABOVE MENTIONED CANDIDATE AS TO HIS/HER FITNESS FOR THE ABOVE MENTIONED POSITION.  DATE / / RECRUITMENT ATTACHE/OR DOCTOR:										
			RECROTTING	Lini	ichbok boc	10K		-			75.00 a	
HISTORY OF AN	Y SIGNIFICANT	PAST ILLNESS INCLUI	DING:									
- PSYCHIATRIC	AND NEUROLO	GICAL DISORDERS (I	EPILEPSY, DEPRES	SSION)						7.10 38.4		
- ALLERGY												
MEDICAL EXAMINATION LARGRATORY INVESTIGATION												
TYPE OF MEDICAL EXAMINATION			NATION   LABORATORY INVEST:   NEGATIVE\   POSITIVE\   TYPE OF LABORATORY								I noorman	
			NORMAL		ORMAL	INVESTIGATION			NEGATIVE\ NORMAL	POSITIVE\ ABNORMAL		
VIS	SION	R. EYE				(URI	NE)					
nym		L. EYE							- SUGAR			
EYE	OTHER	D EVE						- ALBUMIN	7			
	OTHER	R. EYE				-	- BILHARZIASIS					
EAR		R. EAR				(CTO	OL)		- OTHER			
EAR		L. EAR	X-PW-	-		(STO	OL)		HEL MANDELLEO			
CHEST X - RAY		L. LAK		_		- HELMINTHES						
PULMONARY TUBERCULOSIS				-		- SALMONELLA/SHIGELLA - V.CHOLERA						
(SYSTEMIC EXAMINATION)				_		+			- OTHER			
			-		(BLOOD)							
HEART				-		- HEMOGLOBIN			-	-		
LUNGS				-		- MALARIA FILM						
ABDOMEN			-			- OTHERS						
(OTHERS)						(SEROLOGY)						
*HERNIA						- HIV	TEST					
*VARICOSE VEINS								-				
EXTREMITIES						1			- F. B. S.	****		
SKIN					+		. HR	SAG/ANTI HCV				
(VENEREAL DISEASES						-			- L. F. T.			
- CLINICAL						- CREATININE						
- LAB						- UREA						
VDRL						*Mpox (monkeypox) 21 days prior to travel						
TPHA PREGNANCY TEST												
CONFIRM IF T	HE APPLICAT	TON HAS ONE OF T	HE FOLLOWING	7:						NO	YES	
COMMUNICABLE DISEASES												
MENTAL DISORDER												
MENTAL RETARDATION												
PHYSICAL DISORDERS												
HANDICAP												
PARALYSIS												
BLINDNESS HEARING DISORDER												
SPEECH DISORDER												
MENTIONED ABOVE IS THE MEDICAL REPORT FOR MR / MRS / MISS												
PHYSICIAN NAME: SIGNATURE: SIGNATURE: STAMP:												
THIS FORM MUST BE ATTESTED BY ONE OF THE TWO FOLLOWING AUTHORITIES:												
THIS IS TO CE		DR TO PRACTICE MED	ICINE.		LICENSE	NUMB	ER:		, D	EPARTMENT OF (2)	HEALTH	
(1)												
AUTHORIZED SIGNATURE:  STAMP OR SEAL OF THE STATE AUTHORITY (COLLEGE OF PHYSICIANS)												

SUBMIT TO THE CONSULAR SECTION THREE ORIGINALS COPIES OF THIS MEDICAL REPORT AND TWO COPIES OF ALL RESULTS OF THE MEDICAL TESTS,

DO NOT SUBMIT X-RAYS AS THOSE MUST BE PRESENTED TO THE HEALTH AUTHORITIES IN SAUDI ARABIA ALONG WITH ONE CLEAR COPY OF THIS REPORT AND ALL TEST RESULTS.