HEALTH EXAMINATION GUIDELINES FOR FOREIGN WORKERS ENTRY INTO MALAYSIAN CONSTRUCTION INDUSTRY

CSWMS

1. Please read the instructions carefully before filling in the form.
2. Please fill in the form in English and in CAPITAL letters.

INSTRUCTIONS TO CLINIC

1. This form has 5 sections:
   A. Section 1 (PART A) to be filled by the foreign worker; and
   B. Section 1 (PART B), 2, 3, 4 and 5 to be filled by the examining doctor.
2. Please complete all required examination / tests mentioned in this form.

INSTRUCTIONS TO STUDENT

1. All applicants **shall** undergo health examination **within seven (7) working days** upon registration within the CSWMS.
2. Failure in complying with the above requirement will result in rejection of application for CIDB skill competency assessment and certification.
3. Applicants are required to undergo health examination at approved CSWMS Panel Clinics / Health Centres.
4. In the event applicant fails the health examination, the work visa application process will not be processed and the applicant will not be allowed to work in Malaysia.
5. Applicants who fail their health examination may submit their appeal application **within three (3) working days** after receiving health examination result. Any application submitted after the stipulated period will not be entertained.
6. The Government of Malaysia reserves the right to reject any application:
   A. Based on the results of the health examination; and/or
   B. Should there be any evidence that applicant has given false information pertaining to the results of the health examination.

HEALTH EXAMINATION REPORT FOR FOREIGN WORKERS (CONSTRUCTION INDUSTRY ONLY)

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SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT)

PASSPORT NUMBER

EMAIL ADDRESS

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH

AGE

SEX

MARITAL STATUS

ADDRESS

DISTRICT

PROVINCE

COUNTRY

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

The medical practitioner completing this form disclaims any and all liability to the fullest extent permitted by law for any personal injury, suffering or loss caused by any reliance on this information by any other party.

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SECTION 1 (PART B)

Declaration of self and family illness. Explain in full if you or your immediate* family has any of the following illnesses. * Immediate family refers to mother, brothers / sisters.

ITEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	Yes	No	Yes	No	
1. Tuberculosis					
2. Hepatitis B					
3. Hepatitis C					
4. HIV					
5. Drugs use/abuse					
a. Opiates					
b. Methamphetamine					
c. Amphetamine					
d. Cannabinoids					
6. Congenital or Inherited Disorder					
7. Allergy					
8. Mental Illness					
9. Epilepsy					
10. Stroke / Neurological Disease					
11. Diabetes Mellitus					
12. Hypertension					
13. Heart or Vascular Disease					
14. Asthma					
15. Thyroid Disease					
16. Kidney Disease					
17. Cancer					
18. History of Surgery					
19. Sexually Transmitted Diseases					
20. History of Blood Transfusion					
21. Other Illness:					

Current medication (Long Term)

VACCINATION HISTORY (where applicable)	Yes	No	Date of Vaccination
2. BCG			
3. Meningitis (Quadrivalent)			
4. Hepatitis B			
5. Polio			
6. Measles			
7. Rubella			
8. Others: (specify)			

Notes:
1. All students are required to take vaccines as listed in numbers 2-7 above.
2. The workers are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information.

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SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

FULL NAME (AS IN PASSPORT)

PASSPORT NUMBER

DATE OF MEDICAL SCREENING

WORKER'S IDENTIFICATION NUMBER

1. BASIC MEASUREMENT

HEIGHT (m) :	WEIGHT (kg)	BMI(kg/m²)	PULSE RATE (PER MINUTE)	BLOOD PRESSURE: SYSTOLIC (mmHg)	BLOOD PRESSURE: DIASTOLIC (mmHg)

VISION TEST	NORMAL	DEFECTIVE
UNAIDED (L)		
UNAIDED (R)		
AIDED (L)		
AIDED (R)		

COLOR VISION TEST

COMMENT

HEARING ABILITY	NORMAL	DEFECTIVE
LEFT		
RIGHT		

COMMENT

2. GENERAL EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f . SKIN DISEASES			

3. SYSTEMIC EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
g. EYES (including funduscopy)			
h. EARS			
i. NOSE			
j. ORAL CAVITY / THROAT			
k. NECK			
l. CARDIOVASCULAR SYSTEM			
m. RESPIRATORY SYSTEM			
n. ABDOMEN/HERNIAL ORIFICES			
o. NERVOUS SYSTEM			
p. MUSCULOSKELETAL SYSTEM			

SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

4. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A.	**General Appearance**	**Untidy**	**Neat & Tidy**
B.	**Speech Quality**	**No/Abnormal**	**Yes/Normal**
	Coherent		
	Relevant		
C.	**Mood**	**Yes/Abnormal**	**No/Normal**
	Depressed*		
	Anxious		
	Irritable		
D.	**Affect**	**Inappropriate**	**Appropriate**
E.	**Thought**	**Yes/Abnormal**	**No/Normal**
	Delusion		
	Suicidality*		
F.	**Perception**	**Yes/Abnormal**	**No/Normal**
	Hallucination		
G.	**Orientation**	**No/Abnormal**	**Yes/Normal**
	Time		
	Place		
	Person		

*Note: Refer to Questionnaire. If 'Abnormal' for any of item C, E, F or G, to certify as UNSUITABLE.

QUESTIONNAIRE

PART A: MOOD			
		Yes/Abnormal	**No/Normal**
A.	During the past month, have you been feeling down/depressed for most of the days?		
B.	During the past month, have you lost interest in doing things that you like for most of the days?		

If 'Yes' to question A or B, to tick 'Abnormal' at DEPRESSED in assessment box.

PART B: SUICIDALITY			
		Yes/Abnormal	**No/Normal**
C.	Do you feel that life is not worth living?		
D.	Do you have any thoughts about ending your life?		

If 'Yes' to question C or D, to tick 'Abnormal' at SUICIDALITY in assessment box

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SECTION 3 - INVESTIGATIONS

FULL NAME (AS IN PASSPORT)

PASSPORT NUMBER

WORKER'S IDENTIFICATION NUMBER

DATE OF LAB TEST

NAME OF LAB

URINE TEST			
ITEM	**POSITIVE**	**NEGATIVE**	**COMMENT**
a. ALBUMIN			
b. SUGAR			
c. MICROSCOPIC EXAMINATION			
d. OPIATES (INCLUDING CODEINE, MORPHINE, HEROIN)			
e. CANNABINOIDS			
f. AMPHETAMINE TYPE STIMULANT			

BLOOD TEST			
ITEM	**POSITIVE / ABNORMAL**	**NEGATIVE / NORMAL**	**COMMENT**
a. HEPATITIS Bs ANTIGEN			
b. HIV ANTIBODY			
c. HEPATITIS C ANTIBODY			
d. MALARIAL PARASITES			
e. VDRL			
f. TPHA*			

* TPHA is done if VDRL is reactive

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SECTION 4 - CHEST X-RAY INFORMATION

FULL NAME (AS IN PASSPORT)

PASSPORT NUMBER

WORKER'S IDENTIFICATION NUMBER

DATE TAKEN

PLACE TAKEN

CHEST X-RAY NUMBER

COMMENT

ITEM	NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
a. THORACIC CAGE			
b. HEART SHAPE AND SIZE (CTR > 0.55 AND IN FAILURE OR SIGNIFICANT CARDIOMEGALY)			
c. LUNG FIELDS			
d. MEDIASTINUM AND HILAR REGION			
e. PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES			
f. FOCAL LESION			
g. ANY OTHER ABNORMALITIES			
h. IMPRESSION			

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SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (/) the appropriate box

I certify that I have on this date_____examined

Mr. / Ms. _____

Passport Number_____and found him/her with the following disease/condition:

TYPE OF APPLICATION

EMGS REFERENCE NUMBER

ITEM			ABNORMAL
1.	Tuberculosis		
2.	Hepatitis B		
3.	Hepatitis C		
4.	HIV		
5.	Cancer		
6.	Epilepsy		
7.	Psychiatric Illness		
8.	Drugs		
	a.	Opiates	
	b.	Amphetamine/Methamphetamine	
	c.	Cannabinoids	
9.	Malaria		
10.	Sexually Transmitted Disease		
11.	Others (Please Specify)		

HEREBY THE STUDENT IS CERTIFIED AS:

SUITABLE UNSUITABLE

FOR STUDIES/COURSE IN MALAYSIA.

COMMENTS:

NAME OF DOCTOR

DATE

QUALIFICATION

HOSPITAL/CLINIC

REGISTRATION NUMBER