الجامعة الإسلامية العالمية ماليزيا
INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA
Garden of Knowledge and Virtue
GREATER GOMBAK
REGIONAL CENTRE OF EXPERTISE ON EDUCATION FOR SUSTAINABLE DEVELOPMENT
ACKNOWLEDGED BY
UNITED NATIONS UNIVERSITY

HEALTH EXAMINATION REPORT FOR STAFF (NEW APPOINTMENT/CONTRACT RENEWAL)

PASSPORT SIZE PHOTO
(not older than 6 months)

INSTRUCTION: PLEASE FILL IN USING CAPITAL LETTERS
SECTION 1(A) {sections 1 & 3(B) to be completed by the candidate**}**

FULL NAME (AS PER I. C. / PASSPORT)

IDENTITY CARD NO/ PASSPORT NO.

MOBILE PHONE NUMBER

NATIONALITY

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE ☐
FEMALE ☐

MARITAL STATUS
SINGLE ☐
MARRIED ☐
DIVORCED ☐
WIDOWED ☐

STAFF NO.

KULLIYYAH/ CENTRE/ DEPARTMENT/ INSTITUTE/ OFFICE/ MAHALLAH

EMAIL ADDREESS

NAME OF THE NEXT OF KIN (CLOSEST LIVING RELATIVE)

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S MOBILE PH. NUMBER

RELATION WITH THE NEXT OF KIN

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 1(B) – Please tick (√) relevant box

Declaration of health status of self and immediate family (biologic parents & siblings). Explain in full if you have or anyone in the immediate family has any of the following medical problems/ conditions

	MEDICAL PROBLEMS/ CONDITIONS	SELF		IMMEDIATE FAMILY		If 'YES' PLEASE EXPLAIN
		Yes	No	Yes	No	
1	Tuberculosis					
2	Hepatitis B					
3	Hepatitis C					
4	HIV / AIDS					
5	Drugs use/abuse:					
	Opiate					
	Methamphetamine					
	Amphetamine					
	Cannabinoids					
6	Congenital or Inherited disorder(s)*					
7	Drug allergy					
8	Mental disorder(s)					
9	Neurological disorder(s)**					
10	Diabetes mellitus					
11	Hypertension (high blood pressure)					
12	Heart & vessel disease(s)					
13	Bronchial asthma					
14	Thyroid disorder(s)					
15	Kidney disorder(s)					
16	Cancer					
17	History of surgery					
18	Sexually transmitted disease(s)					
19	History of blood transfusion					
20	Hospitalization for COVID-19 treatment					
21	History of smoking					
22	Any other disease(s)					
23	**List of current medication(s)** {if any}					

*Medical conditions present since birth

** Neurological disorders include: Migraines, Epilepsy/ Seizures, Stroke, Motor neuron disease, Dementia/ Alzheimer's disease and Parkinson's disease

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 1(C)

IMMUNIZATION HISTORY (where applicable)		DATE IMMUNIZED				
1	Yellow Fever*					
2	BCG					
3	Meningitis (Quadrivalent)					
4	Hepatitis B					
5	Polio					
6	Measles					
7	Rubella					
8	Covid -19 (include TYPE of vaccine, e.g. pfizer)					
9	Others - (please specify)					

*A valid Yellow Fever vaccination certificate is required from all travelers coming from or having transited (more than 12 hours) through countries with risk of Yellow Fever transmission

The candidate is expected to have got vaccines listed in the above table at numbers 2-8

The candidate is required to bring along the International Certificate of Vaccination for verification of information

If you have sought consultation for any of the listed diseases/conditions on page 2, you are required to submit your medical history/report from your treating physician.

I hereby certify that the information given above is true. I also understand that my application/ registration will be rejected/cancelled in case the information given was found untrue

…….. **Date**

…… **Name of the candidate**

…… **Signature of the candidate**

…… **I. C. /Passport number of the candidate**

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 2 - PHYSICAL EXAMINATION (Sections 2, 3A, 4 & 5 to be completed by the examining doctor)

1. BASIC MEASUREMENTS	
HEIGHT (CM):_____ **WAIST CIRCUMFERENCE** (CM):_____	**WEIGHT** (KG): _____ **BMI** (KG/M^2): _____
BLOOD PRESSURE (mm Hg): Systolic: _____ / Diastolic :_____	**PULSE RATE** (beats/ min):_____
VISION TEST : Unaided : (R): __ /__ (L) __ /__ Aided : (R): __ / __(L)__ / __	**COLOUR VISION TEST**: NORMAL ☐ ABNORMAL ☐
HEARING ABILITY: Right Ear : NORMAL ☐ ABNORMAL ☐ Left Ear : NORMAL ☐ ABNORMAL ☐	**COMMENTS:**

2. GENERAL EXAMINATION				
ITEM		**YES**	**NO**	**COMMENT**
A	CYANOSIS			
B	DEFORMITIES			
C	JAUNDICE			
D	NAIL ORDERS			
E	OEDEMA			
F	PALLOR			
G	SKIN DISORDERS			

3. SYSTEMIC EXAMINATION				
ITEM		**NORMAL**	**ABNORMAL**	**COMMENT**
A	ABDOMEN			
B	CARDIOVASCULAR SYSTEM			
C	EARS			
D	EYES {including funduscopy (if possible)}			
F	HERNIAL ORIFICES			
G	MUSCULOSKELETAL SYSTEM			
I	NECK			
J	NERVOUS SYSTEM			
K	NOSE			
L	ORAL CAVITY/ THROAT			
M	RESPIRATORY SYSTEM			

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 3(A) - MENTAL HEALTH ASSESSMENT
(assessment by the examining doctor)

A	General appearance		Neat & tidy		Untidy	
B	Speech quality	Coherent	Yes		No	
		Relevant	Yes		No	
C	Mood	Depressed	Yes		No	
		Anxious	Yes		No	
		Irritable	Yes		No	
D	Affect		Appropriate		Inappropriate	
E	Thought:					
	Delusion		Yes		No	
	Suicidality		Yes		No	
F	Perception:					
	Hallucination		Yes		No	
G	Orientation in :					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 3(B) - MENTAL HEALTH ASSESSMENT

{QUESTIONNAIRE} (declaration by the candidate)

1. MOOD		YES	NO
A	Feeling depressed or having low mood most of the days, nearly every day **for the past 1 month**, may be subjective (e.g. feels sad,empty, hopeless) or observed by others (e.g. appears tearful)		
B	Markedly reduced interest/pleasure in all (or almost all) activities most of the day, nearly every day, may be subjective or observed by others		
C	Difficulty to sleep almost every night		

2. SUICIDALITY:		YES	NO
A	Feeling worthless or excessive / inappropriate guilt almost everyday		
B	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or suicide attempt or a specific plan for suicide		

3. PSYCHOSIS:		YES	NO
A	Seeing images or hearing sounds that occurs (that you feel is real) in the absence of an actual external stimulus observed by others		
B	Continuously believe that some body is controlling your every move via radio waves or other methods		

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 4 - INVESTIGATIONS

1. URINE TEST				
ITEM		**POSITIVE**	**NEGATIVE**	**COMMENT**
A	ALBUMIN			
B	SUGAR			
C	OPIATES (including codeine,morphine & heroin)			
D	CANNABINOIDS			
E	AMPHETAMINE TYPE STIMULANTS			
F	MICROSCOPIC EXAMINATION			

2. BLOOD TESTS				
ITEM		**POSITIVE/ ABNORMAL**	**NEGATIVE/ NORMAL**	**COMMENT**
A	HEPATITIS B ANTIGEN			
B	HEPATITIS C ANTIBODY			
C	HIV ANTIBODY			
D	MALARIAL PARASITES*			
E	VDRL / TPHA**			
F	FULL BLOOD COUNT			
G	FASTING BLOOD SUGAR			
H	HBA1C			
I	RENAL PROFILE			
J	LIVER FUNCTION TEST			
K	SERUM URIC ACID			
L	LIPID PROFILE			
M	THYROID FUNCTION TEST			
N	UFEME			

*Not applicable to Malaysian candidate unless indicated

**TPHA will be done ONLY if VRDL found positive

Full details of blood test results are MANDATORY & must be enclosed with this form

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

3. CHEST X-RAY:	
CHEST X-RAY FILM NO.	
DATE TAKEN	
PLACE TAKEN	

DOCTOR'S REPORT:

	ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
A	THORACIC CAGE			
B	HEART SHAPE & SIZE			
C	LUNG FIELDS			
D	MEDIASTINUM & HILAR REGION			
E	PLEURA /HEMIDIAPHRAGMS & COSTOPHRENICANGLES			
F	ANY OTHER ABNORMALITIES			
G	OVER ALL IMPRESSION			

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) the appropriate box:

It is certified that I have on this date _____examined

Mr. / Ms. _____I. C. / Passport/ No._____

and found him / her with the following disease(s)/condition(s) as shown in the below table:

ITEM		YES	NO
1	Tuberculosis		
2	Hepatitis B		
3	Hepatitis C		
4	HIV		
5	Cancer		
6	Epilepsy		
7	Psychiatric Illness		
8	Drugs :		
	Opiates		
	Methamphetamine		
	Amphetamine		
	Cannabinoids		
9	Others (Please specify)		

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

IT IS HEREBY CERTIFIED THAT:

☐ The above name is in good health & fit to work

☐ The above name has the following medical condition(s):

1. _____ 2. _____
3. _____ 4. _____

☐ The above name is on the following medication(s):

1. _____ 2. _____
3. _____ 4. _____

☐ The above name is unfit to work for IIUM

…… ……..

Signature of Doctor Date

Name of Doctor : _____

Official stamp :

Verification by the IHWC Medical Officer/ Physician (If Medical Check Up done at any place other than IHWC/FHC)

…… ……..

Signature of Doctor Date

Name of Doctor : _____

Official stamp :

FULL NAME (AS PER I. C. / PASSPORT) & STAFF NO.

CONSENT FORM FOR SEXUALLY TRANSMITTED DISEASES (STDs)/DRUGS SCREENING
BORANG PERSETUJUAN SARINGAN PENYAKIT KELAMIN/DADAH

MEDICAL OFFICER / *PEGAWAI PERUBATAN*,

I_____

Staff No. _____ I. C. / Passport No._____

hereby agree **to undergo STDs/ drugs screening** at the IIUM Health and Wellness Centre.

I fully understand the implications involved with the above-mentioned procedure.

*Saya*_____

*No. Staff*_____*No. Kad Pengenalan/ No. Pasport*_____

dengan ini bersetuju untuk menjalani saringan penyakit kelamin/ dadah di Pusat Kesihatan & Kesejahteraan UIAM. Saya memahami sepenuhnya implikasi yang terlibat dengan prosedur di atas.

Signature of the candidate/*Tandatangan Calon*

_____

Name of the candidate /*Nama Calon*

_____

I. C. / Passport No.:
No. Kad Pengenalan / No. Pasport:

_____

Date / *Tarikh*: _____

Signature of the witness/*Tandatangan Saksi*

_____

Name of the witness/*Nama Saksi*

_____

I. C. / Passport No.:
No. Kad Pengenalan / No. Pasport:

_____

Date / *Tarikh* : _____