

MEDICAL INFORMATION

This information should be submitted at the time of interview
MEDICAL INFORMATION (to be completed by a registered physician only)

Name of applicant Date of birth

Blood pressure : MM/HG Height (Cm) Weight (Kg.) Pulse rate

CLINICAL EVALUATION

Please tick each item	Normal	Abnormal	Details of abnormalities				
			Yes	No			
1. Skin	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="text"/>
2. Head & Neck	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Sinus	<input type="text"/>
3. Ears & Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Spectacles	<input type="text"/>
4. Mouth & Throat	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>		<input type="text"/>
5. Chest & Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
6. Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
7. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
8. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
9. Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
10. Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
11. Vertebral column, specify any problems			<input type="text"/>				
12. Legs & Feet, various veins, arteries etc.			<input type="text"/>				

REQUIRED LABORATORY

Hemoglobin (Specify units % Blood Group

Urinalysis – Albumin %

Sugar %

Sediment %

Has the applicant been immunized against any of the following ? (these are compulsory) :

Diphtheria*	<input type="text"/>	<input type="text"/>
Whooping Cough*	<input type="text"/>	<input type="text"/>
Tetanus*	<input type="text"/>	<input type="text"/>
Poliomyelitis	<input type="text"/>	<input type="text"/>

*specify number of doses & dates

GENERAL INSPECTION

a) The undersigned doctor certifies that the general state of health, physical and mental condition of the applicant is excellent. That he is not the carrier of infectious disease and has no physical disability. The applicant can therefore comply with the strict requirement of a professional training in the hotel and restaurant industry without risk.

b) He also certifies that the candidate is not obliged to follow a special diet.

Date

Signature and stamp of the Doctor