

**CONFIDENTIAL**



**HUMAN CAPITAL DEVELOPMENT  
DIVISION**  
*Bahagian Pembangunan Modal Insan*  
**PUBLIC SERVICE DEPARTMENT (PSD)**  
*Jabatan Perkhidmatan Awam (JPA)*

**HEALTH DECLARATION  
AND MEDICAL EXAMINATION FORM**  
*Borang Pengakuan dan Pemeriksaan Kesihatan*

**Instruction : (Kindly use Black ink ball pen to fill up this form)**

- (i) Health Declaration - to be completed by student
- (ii) Medical Examination - to be completed by certified physician

**Note : Student is responsible to return this form to PSD once completed**

***Arahan : (Sila gunakan pen mata bola berdakwat HITAM sahaja untuk mengisi borang ini)***

- (i) *Pengakuan Kesihatan* - *diisi oleh pelajar*
- (ii) *Pemeriksaan Kesihatan* - *diisi oleh pegawai perubatan bertauliah*

***Nota :Pelajar adalah bertanggungjawab untuk mengembalikan borang yang telah lengkap diisi ke JPA***

**\*Pemeriksaan kesihatan untuk kanak-kanak dan bayi, bergantung kepada keperluan yang ditentukan oleh Pegawai Perubatan yang berkenaan.**

**\*For children and babies, the Medical Officer can determine which particular medical checkup is relevant and valid.**

## PERSONAL DETAILS

*Maklumat Peribadi*

<b>Name</b> <i>Nama</i>	<b>I.C. No</b> <i>No.KP</i>	<b>Date of Birth</b> <i>Tarikh Lahir</i>  / /
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**Sex : M [ ] F [ ] Marital Status : Single [ ] Married [ ] Other : \_\_\_\_\_**  
*Jantina L P Status Perkahwinan Bujang Berkahwin Lain-lain*

<b>Home Address</b> <i>Alamat Kediaman</i>	<b>Contact Number</b> <i>No untuk dihubungi</i>  (H)R : (H/P) I.B :
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<b>Name, relationship and address of next of kin</b> <i>Nama hubungan dan alamat waris</i>	<b>Contact Number</b> <i>No untuk dihubungi</i>  (H)R : (H/P) I.B :
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## HEALTH DECLARATION

### *Pengakuan Kesehatan*

**Have you or your family members ever suffered any of the following conditions?**

*Pernakah anda atau keluarga terdekat mengalami masalah-masalah kesehatan berikut?*

**Please mark X in an appropriate column/ Tandakan X di ruang berkenaan**

SN	ILLNESS	Student <i>Pelajar</i>		Family Member <i>Ahli Keluarga</i>	
		YES	NO	YES	NO
1.	Psychiatric illness / ( <i>Sakit Jiwa</i> )				
2.	Epilepsy / ( <i>Sawan</i> )				
3.	Migraine / ( <i>Migrain</i> )				
4.	Hysteria / ( <i>Histeria</i> )				
5.	Allergic Rhinitis / ( <i>Resdung</i> )				
6.	Asthma / ( <i>Lelah</i> )				
7.	Tuberculosis (PTB) / ( <i>Batuk Kering</i> )				
8.	Hypertension (HPT) / ( <i>Darah Tinggi</i> )				
9.	Diabetes Mellitus (DM) / ( <i>Kencing Manis</i> )				
10.	Heart Diseases / ( <i>Penyakit Jantung</i> )				
11.	Thyroid Diseases / ( <i>Penyakit Tiroid</i> )				
12.	Kidney Diseases / ( <i>Penyakit Buah Pinggang</i> )				
13.	Gastric / ( <i>Penyakit Gastrik</i> )				
14.	HIV / AIDS				
15.	Cancer / ( <i>Barah</i> )				
16.	Venereal Diseases / ( <i>Penyakit Kelamin</i> )				
17.	Leukemia / ( <i>Leukimia</i> )				
18.	Hepatitis / ( <i>Hepatitis</i> )				
19.	Blood Stained Sputum ( <i>Kahak Berdarah</i> )				
20.	Other Lung Diseases/ ( <i>Lain-lain Penyakit Paru-Paru</i> )				
21.	Joint Pain /( <i>Sengal-sengal sendi</i> )				
22.	Swelling of Legs /( <i>Bengkak Kaki</i> )				
23.	Giddines/ ( <i>Pening Kepala</i> )				
24.	Hernia/ ( <i>Burut</i> )				
25.	Drug Addiction/ ( <i>Ketagihan Dadah</i> )				
26.	Allergic/ ( <i>Alahan</i> )				
27.	Surgical Operation/ ( <i>Pembedahan</i> )				
28.	Disability or Handicap/ ( <i>Kecacatan</i> )				

**If yes, please give details** (*Jika Ya, sila nyatakan butiran lanjut*)

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**Please State (Sila nyatakan)**

Other illnesses / (*Penyakit-penyakit lain*)

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Operation/Surgical (Minor/Major) / (*Pembedahan Besar/ Kecil*)

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Details of Allergies / (*Butiran lanjut mengenai Alahan*)

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Family Medical History/ (*Sejarah Kesihatan Keluarga*)

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Details of Disability/Handicap/ (*Butiran lanjut mengenai Kecacatan*)

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History of Blood Transfusion / (*Sejarah Perpindahan Darah*)

Number of Transfusion	Date of Transfusion	Amount Transfused	Reasons for Transfusion

Please mark X in an appropriate column / *Tandakan X di ruang berkenaan.*

Smoking :  YES/Ya  NO/Tidak  
*Merokok*

If yes : a) Duration/*Tempoh* : .....Year /*Tahun*

b) No. of sticks per day/*Jumlah batang rokok sehari* : .....

I hereby certify that the above information are true and complete, and agree that any misrepresentation or deliberate omissions of a material fact on this form may result in me not being permitted to enter a program, or may result in termination and I will be required to pay back the whole expenses incurred by PSD. I hereby grant The Human Capital Division, PSD permission to share information contained herein with relevant authorities.

*Saya dengan ini mengaku maklumat di atas adalah benar dan lengkap dan bersetuju sekiranya terdapat maklumat yang tidak benar atau dengan sengaja tidak menyatakan perihal sebenar di dalam borang ini akan menyebabkan saya tidak dibenarkan mengikuti program yang ditawarkan, atau menghadapi kemungkinan ditamatkan daripada program dan dituntut perbelanjaan sebenar. Saya dengan ini memberi kebenaran kepada Bahagian Pembangunan Modal Insan, JPA untuk berkongsi maklumat yang terdapat di dalam Borang Pemeriksaan Kesihatan saya dengan pihak-pihak yang berkenaan.*

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Signature/ *Tandatangan*

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Date/ *Tarikh*

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## MEDICAL EXAMINATION

*(The Physician must complete all questions, give additional comment where necessary and responsible for the information, suggestion and recommendation regarding the student's health given in this form)*

**Student Name and I.C. Number**

**Date of Birth**

/ /

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## PHYSICAL EXAMINATION

WEIGHT	HEIGHT
BLOOD PRESSURE	PULSE

VISION				
	<b>Acuity Test</b>		<b>R</b>	<b>L</b>
		Without glass		
		With glass		
Colour Test :				

**Are there abnormalities of the following systems? If yes, describe fully using additional sheet if necessary**

	<b>SYSTEMS</b>	<b>Normal</b>	<b>Abnormal (Please provide additional information)</b>																									
1	Skin																											
2	Ear Nose Throat																											
3	Cardiovascular		BP  Pulse  Rhythm  Heart Murmur																									
4	Respiratory																											
5	Gastrointestinal																											
6	Genitourinary (incl. Venereal Diseases such as HIV/AIDS)																											
7	Central and Peripheral Nervous System		<table border="1"> <thead> <tr> <th></th> <th colspan="2">Upper limb</th> <th colspan="2">Lower limb</th> </tr> <tr> <th></th> <th>L</th> <th>R</th> <th>L</th> <th>R</th> </tr> </thead> <tbody> <tr> <td>Power</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Reflexes</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Others</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Upper limb		Lower limb			L	R	L	R	Power					Reflexes					Others				
	Upper limb		Lower limb																									
	L	R	L	R																								
Power																												
Reflexes																												
Others																												
8	Psychiatric (Mental State Examination)																											
9	Lymphatic System																											
10	Reproductive system		If case of pregnancy, please provide further details:  Last Menstrual Date =  Period of Amenorrhea =  Expected Date of Delivery =																									

**A. INVESTIGATIONS:**

ALL TESTS LISTED BELOW ARE MANDATORY:

<b>SN</b>	<b>TESTS</b>	<b>RESULTS</b>																
1.	Urine	<p><b>For All candidates</b></p> <p><b>URINE TEST</b></p> <table border="1"> <tr> <td><b>NAD</b></td> <td></td> <td><b>WBC</b></td> <td></td> <td><b>RBC</b></td> <td></td> </tr> <tr> <td><b>PROTEIN</b></td> <td></td> <td><b>GLUCOSE</b></td> <td></td> <td><b>DRUG</b></td> <td></td> </tr> </table> <p><b>For Ladies only:</b> Pregnancy test (for ladies only) –</p> <p><b>PREGNANCY TEST</b></p> <table border="1"> <tr> <td><b>POSITIVE</b></td> <td></td> <td><b>NEGATIVE</b></td> <td></td> </tr> </table>	<b>NAD</b>		<b>WBC</b>		<b>RBC</b>		<b>PROTEIN</b>		<b>GLUCOSE</b>		<b>DRUG</b>		<b>POSITIVE</b>		<b>NEGATIVE</b>	
<b>NAD</b>		<b>WBC</b>		<b>RBC</b>														
<b>PROTEIN</b>		<b>GLUCOSE</b>		<b>DRUG</b>														
<b>POSITIVE</b>		<b>NEGATIVE</b>																

2.	Chest X-Ray	
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3.	Blood		
		Positive	Negative
	<b>HEPATITIS B</b>		
	<b>HIV/AIDS</b>		
	<b>VDRL</b>		
	<b>TPHA</b>		

4.	Mantoux test	(For candidate who study in USA only)
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Other discretionary tests undertaken if necessary:

<b>TESTS</b>	<b>RESULTS</b>



Is the student now under treatment for any physical or emotional condition?

By history and physical examination, is this student a carrier of any communicable disease?

**B. RECOMMENDATION:**

Medically fit	
Medically fit with limited capability	Please explain.
Medically Not fit	Please explain.

I hereby certify that I have examined \_\_\_\_\_  
I/C No. \_\_\_\_\_ including x-ray and I confirmed that the  
candidate is **\*MEDICALLY FIT/ UNFIT (\*delete where appropriate)** to enter  
the program.

**PHYSICIAN'S FULL NAME:** \_\_\_\_\_

**NO. K/P (I/C NO.)** \_\_\_\_\_

**POST AND QUALIFICATION** \_\_\_\_\_

**COP RASMI (OFFICIAL SEAL)** \_\_\_\_\_

X \_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN'S SIGNATURE**

**DATE**

**Note :** In completing this form, particular attention should be paid to the following points :-

- (a) X-ray of chest to rule out any tuberculosis or chronic pulmonary disease: where the film is entirely normal it needs not be forwarded but if any abnormality is noted the film should be sent with this report.
- (b) Kidneys – no evidence of renal lesion should be present
- (c) Eyesight – severe errors of refraction should be not passed as these should only give trouble during the years of study.
- (d) Hearing – deafness be considered a definite bar.