



MEDICAL REPORT

for person applying to live temporarily in Samoa

This form is to be completed by a registered medical practitioner after personally examining the applicant.

Attach a passport-sized photo of the applicant here

PART A. TO BE COMPLETED BY THE APPLICANT BEFORE VISITING THE DOCTOR

1. Family name 2. Given name
3. Gender 4. Date of birth 5. Occupation

6. How long do you intend staying in Samoa?

7. Your medical history:

Have you ever had:

Please tick YES or NO

If yes, provide details

- | | | | |
|--|--------------------------|--------------------------|----------------------|
| (a) an operation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (b) been admitted to hospital? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (c) have you previously suffered or presently suffering from any communicable diseases for more than 2 weeks
eg. Tuberculosis other <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (d) an abnormal x-ray? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (e) convulsions, fits or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (f) anxiety, depression or nervous complaints requiring treatment/
Counselling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (g) high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (h) heart trouble, chest pains or breathlessness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (i) kidney or bladder disease or complaint? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (j) any illness, injury or medical condition lasting more than 2 weeks or a recurring condition not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (k) are you taking any pills, medicine or having any other medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (l) have you ever been addicted to a drug or taken drugs illegally? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (m) do you consume alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (n) do you smoke, or have you ever smoked tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (o) Do you have a medical condition that may require periodic hospitalisation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

APPLICANT'S DECLARATION - to be signed in the presence of the examining doctor.

I declare that the information I have provided on this form is correct.

Signature

Date

PART B: EXAMINING DOCTOR'S FINDINGS

8. Height Weight Blood pressure BSL

Please tick
Normal or Abnormal Details

- | | | | |
|--|--------------------------|--------------------------|---|
| 9. Cardiovascular system
(record any evidence of heart murmurs, cardiac failure, irregularity or other heart abnormality) | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 10. Respiratory system
(for current or previous TB, provide date and duration of treatment and name, strength and dosage of drugs used) | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 11. Nervous system | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 12. Mental state | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 13. Gastrointestinal system including hernia orifices | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 14. Locomotor system/physical build/mobility | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 15. Skin and lymph nodes | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 16. Endocrine system | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 17. Ear/nose/throat/mouth/teeth | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 18. Hearing | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| Left | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| Right | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 19. Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 20. VDRL test result - only in clinically indicated | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |

Please tick
Positive or Negative Details

- | | | | |
|--|--------------------------|--------------------------|---|
| 21. Hepatitis B antigen test result | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |
| 22. Human Immunodeficiency Virus test result: please repeat and perform Western Blot test. (Pre-test and post-test counselling for positive results is mandatory). | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 100%;" type="text"/> |

23. Urinalysis: Blood Albumin Sugar

24. Stool Culture mandatory for people coming to Samoa as food handlers and teachers

DOCTOR'S CONCLUSIONS: Please consider the information you have provided about this applicant. Please consider if the applicant has the potential to be a health risk in Samoa or a financial burden to Samoa. Please tick the appropriate box:

No significant history or abnormal findings present
 Significant history or abnormal findings present - please attach details
 Subject to following condition:

Doctor's signature	Doctor's Full Name	Contact phone	Date