الجامعة الإسلامية العالمية ماليزيا
INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA
Garden of Knowledge and Virtue

GREATER GOMBAK

RCE REGIONAL CENTRE OF EXPERTISE ON EDUCATION FOR SUSTAINABLE DEVELOPMENT
ACKNOWLEDGED BY
UNITED NATIONS UNIVERSITY

HEALTH EXAMINATION REPORT
(for New Staff Appointment/Renewal Contract)

STAFF'S PASSPORT PHOTOGRAPH

INSTRUCTION: PLEASE FILL IN USING CAPITAL LETTERS

SECTION 1 (To be completed by candidates)

(PART A)

FULL NAME

IDENTITY CARD NO/ PASSPORT NO.

CONTACT NUMBER

NATIONALITY

DATE OF BIRTH

D D M M Y Y

AGE

SEX

MALE

FEMALE

MARITAL STATUS

SINGLE

MARRIED

STAFF ID

K/C/D/I/O

EMAIL ADDREESS

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

FULL NAME & STAFF NO.

SECTION 1 (PART B) – Please tick (√) in the relevant box
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 father, mother, brothers / sisters

MEDICAL PROBLEMS		SELF		IMMEDIATE FAMILY		If "Yes" please state.
		Yes	No	Yes	No	
1	Tuberculosis					
2	Hepatitis B					
3	Hepatitis C					
4	HIV / AIDS					
5	Drugs use/abuse a. Opiate b. Methamphetamine c. Amphetamine d. Cannabinoids					
6	Congenital or Inherited					
7	Drug 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 Disease					
20	History of Blood Transfusion					
21	Hospital Admission for Treatment of COVID-19 Positive					
22	Other Illnesses					

If you have sought consultation for any of the listed disease/condition, you are required to submit your medical history/report from your treating physician. I hereby certify that the information given above is true.

………………………………… ………………………………………………………………………………..
Date **Name of staff**

………………………………….. ……………………………………………………………….
Signature of Staff **Staff's IC/Passport number**

FULL NAME & STAFF NO.

IMMUNIZATION HISTORY (where applicable)		DATE IMMUNIZED				
1	Yellow Fever					
2	BCG					
3	Meningitis (Quadrivalent)					
4	Hepatitis B					
5	Polio					
6	Measles					
7	Rubella					
8	Others: (specify)					

Notes:

1. * A valid Yellow Fever vaccination certificate is required from all travelers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.
2. The staff are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information.

I hereby certify that the information given above is true. I understand that my application/ registration will be rejected/cancelled if there is any false information given.

………………………….. ……………………………………………

Date Signature of staff

FULL NAME & STAFF NO.

SECTION 2 - PHYSICAL EXAMINATION (To be filled by examining doctor)

1. BASIC MEASUREMENT	
HEIGHT :____________________m	WEIGHT :____________________kg BMI :____________________kg/m²
BLOOD PRESSURE Systolic :________________________mmHg Diastolic :___________________mmHg	PULSE RATE :________________/ min
VISION TEST : Unaided : (R)_________(L) _________ Aided : (R)_________(L) _________	COLOUR VISION TEST : NORMAL / ABNORMAL
HEARING ABILITY Left : NORMAL / ABNORMAL Right : NORMAL / ABNORMAL	COMMENT:

2. GENERAL EXAMINATION				
ITEM		YES	NO	COMMENT
a.	DEFORMITIES			
b.	PALLOR			
c.	CYANOSIS			
d.	JAUNDICE			
e.	OEDEMA			
f.	SKIN DISEASES			

3. SYSTEMIC EXAMINATION				
ITEM		YES	NO	COMMENT
a.	EYES (including funduscopic)			
b.	EARS			
c.	NOSE			
d.	ORAL CAVITY / THROAT			
e.	NECK			
f.	CARDIOVASCULAR SYSTEM			
g.	RESPIRATORY SYSTEM			
h.	ABDOMEN / HERNIA ORIFICES			
i.	NERVOUS SYSTEM			
j.	MUSCULOSKELETAL SYSTEM			

FULL NAME & STAFF NO.

3. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A.	General Apprearance		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		Appropiate		Inappropiate	
E.	Thought					
	Delusion		Yes		No	
	Suicidality*		Yes		No	
F.	Perception					
	Hallucination		Yes		No	
G.	Orientation					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

FULL NAME & STAFF NO.

QUESTIONNAIRE (DECLARATION BY STAFF)

PART A : MOOD		YES	NO
A.	Feeling depressed or low mood most of the day, 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.		
If 'Yes' to question 1 or 2, to tick 'Yes' at DEPRESSED in assessment box.			

PART B : SUICIDALITY		YES	NO
A.	Feeling worthless or excessive/inappropriate guilt almost every day.		
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.		
If 'Yes' to question 3 or , to tick 'Yes' at SUICIDALITY in assessment box.			

PART C : PSYCHOSIS		YES	NO
A.	Seeing image or hearing sounds that occurs (that you feel it is real) in the absence of an actual external stimulus observed by others.		
B.	Continuously believe that somebody is controlling your every move via radio waves or other methods.		
If 'Yes' to question 3 or, to tick 'Yes' at PSYCHOSIS in assessment box.			

FULL NAME & STAFF NO.

SECTION 3 - INVESTIGATIONS

URINE TEST				
ITEM		POSITIVE	NEGATIVE	COMMENT
a.	UFEME			
b.	OPIATES (including Codeine, Morphine, Heroin)			
c.	CANNABINOIDS			
d.	AMPHETAMINES TYPE STIMULANT			

BLOOD TEST				
ITEM		POSITIVE/ ABNORMAL	NEGATIVE/ NORMAL	COMMENT
a.	HEPATITIS B's ANTIGEN			
b.	HIV ANTIBODY			
c.	HEPATITIS C ANTIBODY			
d.	MALARIA 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			

*TPHA is done if VRDL is reactive

* Full details of blood test results are **MANDATORY** to be enclosed with this form.

FULL NAME & STAFF NO.

X-RAY REPORT

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	

	ITEM	NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
A.	THORACIC CAGE			
B.	HEART SHAPE & SIZE (CTR > 0.55 & IN FAILURE OR SIHNIFICANT CARDIOMEGALY			
C.	LUNG FIELDS			
D.	MEDIASTINUM & HILAR REGION			
E.	PLEURA/HEMIDIAPHRAGMS/COSTOPHRENIC ANGLES			
F.	FOCAL LESION			
G.	ANY OTHER ABNORMALITIES			
H.	IMPRESSION			

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box:

I certify that I have on this date______________________________examined

Mr / Ms ____

Passport No. ____________________________________and found him / her with the following disease/condition: -

	ITEM	ABNORMAL
1	Tuberculosis	
2	Hepatitis B	
3	Hepatitis C	
4	HIV	
5	Cancer	
6	Epilepsy	
7	Psychiatric Illness	
8	Drugs : a. Opiates b. Methamphetamine c. Amphetamine d. Cannabinoids	
9	Others (Please specify)	

HEREBY THE STAFF IS CERTIFIED AS:

☐ SUITABLE ☐ UNSUITABLE

FOR WORKING IN IIUM

COMMENTS:

____

....
Signature of Doctor

....
Date

Name of Doctor : ____

Qualification : ____

Hospital/Clinic : ____

Registration Number : ____

Official stamp :

CONSENT FORM FOR SEXUAL TRANSMITTED DISEASE (STD) SCREENING

Dear Doctor,

I, ………..

Staff No…………………………… I/C No./Passport No.. hereby agree

on the blood test for STD screening at the IIUM Health and Wellness Centre.

Signature of Staff : ……………………………

Name of Staff:...

I/C No./Passport No :.......................................

Date :…………………………………..

Signature of Witness: ……………………….

Name of Witness:..

I/C No./Passport No :.......................................

Date :…………………………………..