Tel: (65) 6222 3322
Fax: (65) 6224 9221
Singapore General Hospital
Outram Road
Singapore 169608
www.sgh.com.sg

Reg No 198703907 Z

Medical Examination Report

PART I ***(To be completed by Student)***
Personal Particulars:

Full Name: ____
(Underline Surname / Family Name)

Sex: Male / Female   Marital Status: ______________________________

Course of Study: ______________________________   Date & Place of Birth: ______________________________

NRIC / Passport No: ______________________________   Nationality: ______________________________
(Citizenship Status)

Home Address: ____

____

Tel No (Home): ______________________________   (Mobile): ______________________________

Email Address: ____

Next of Kin's Name: ______________________________   Relationship: ______________________________

Next of Kin's Occupation: ____

Do you smoke? No [ ] Yes [ ] Number of sticks per day / week ___________ Number of Years ___________

1) Are you currently under treatment for any physical condition? No [ ] Yes [ ].
If yes, please provide details.

____

____

2) Are you currently under treatment or have been treated in the last five years by a psychiatrist, clinical psychologist, or other mental health professionals? No [ ] Yes [ ]
If yes, please provide details (diagnosis, treatment, date and duration, etc. – Please use separate sheet if necessary).

____

____

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Personal Medical History:

Have you suffered from or undergone any of the following?
(Please tick [√] No or Yes. If "Yes" please specify condition and duration).

	No	Yes	Details
Allergies			
Acute / Chronic Respiratory Disorders			
Blood Disorders			
Gastro – intestinal Disorders			
Menstrual Disorders			
Muscular or Joint Disorders			
Skin Disorders			
Surgical Procedures			
Any other conditions (e.g. Hepatitis B Carrier, G6PD deficiency)			

I hereby certify that the answers given by me to the above listed questions are correct and true. I understand that SGH shall not bear the costs of treatment of any medical impairment, illness or investigation that may arise. I have no objection to the release of my medical report(s) from the hospital(s) or doctor(s) concerned, if necessary.

Signature of Student: ___________________________________ Date: ______________________________________

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PART II *(Medical Examination)*

Full Name: ______________________________________ NRIC / Passport No: ____________________________

Height: ____________________M Weight: ____________________KG

Laboratory Examination:

HEPATITIS B ANTIBODY *(Both Step 1 and Step 2 are required)*	**Step 1.** Vaccine Series Vaccine # 1___________________/__________ Vaccine # 2____________/_____/__________ Vaccine # 3____________/_____/__________ Three total doses given at 0, 1-2, and 4-6 months. **Step 2.** Proof of Immunity (Hepatitis B Surface Antibody) Date of Antibody blood titer:______/_____/__________ Result:_________________________________ *(must attach a copy of lab test in English)*
HEPATITIS B SURFACE ANTIGEN	Date of Antigen blood titer:_____/__________/______ Result:_________________________________ *(must attach a copy of lab test in English)*
HEPATITIS C (Hepatitis C Antibody)	Date of blood titer:_____/_____/_______________ Result:_________________________________ *(must attach a copy of lab test in English)*
HIV SEROLOGY	Date of blood titer:_____/_____/_______________ Result:_________________________________ *(must attach a copy of lab test in English)*
VARICELLA ZOSTER/ CHICKENPOX	Date of blood titer:_____/_____/_______________ VZV IgG Result:__________________________*(must attach a copy of lab test in English)* *- OR -* Dates of immunization if you have not had chickenpox: *(Two doses separated by at least 30 days are required)* Vaccine # 1____________/_____/__________ Vaccine # 2____________/_____/__________
TETANUS/ DIPHTHERIA/ PERTUSSIS	1 dose (Tdap as an adult) is needed to be considered immune. Date of Tdap Vaccine:_____/_____/__________

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MEASLES	Date of blood titer:______/______/___________ Result:___________________________________*(must attach a copy of lab test in English)*
MUMPS	Date of blood titer:______/______/___________ Result:___________________________________*(must attach a copy of lab test in English)*
RUBELLA	Date of blood titer:______/______/___________ Result:___________________________________*(must attach a copy of lab test in English)*

OR

MEASLES, MUMPS, RUBELLA (MMR) VACCINE	MMR #1 Date of Live Vaccine__ /______/___________ MMR #2 Date of Live Vaccine__ /______/___________ (must be given at least 28 days after MMR #1) - **OR** - If individual vaccines were received for Measles, Mumps, and Rubella, please complete the following: Measles Vaccine Date of Vaccine # 1______/______/___________ Date of Vaccine # 2______/______/___________ Rubella Vaccine Date of Vaccine # 1______/______ / ___________ Date of Vaccine # 1______/______/___________ Mumps Vaccine Date of Vaccine # 1______/______/___________ Date of Vaccine # 2 ______/______/___________

Conclusion:
(Please conclude and indicate if student is fit to undertake a clinical posting in Singapore with a [√]):

Fit	Unfit	Date of Examination:

Physician's Name: ______________________________ Signature: ____

Clinic's Stamp and Address: ____

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Notes:

1. The Medical Examination may be done in their home countries / places of residence at any medical clinic licensed to carry out such tests.
2. This Medical Examination Report is to be completed by a registered doctor and returned to the examinee.
3. Please attach all results of blood tests and HIV reports to this examination report before submission.
4. The Medical Examination Report and Results of Blood Tests must not be dated more than 6 months from the date of application.

Please email the completed examination report to;

adminado@sgh.com.sg

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Guidelines for immunization compliance

Your health and the health of our patients are our main concern. Please review the following information carefully in order to be eligible for the Electives Programme. We adhere strictly to these immunization guidelines.

Hepatitis B Screening and Immunity

Please attach documentary proof that you have been screened and tested negative for the Hepatitis B surface antigen (HBsAg) and has proof of immunity.

Applicants who have not been previously screened for the Hepatitis B virus are required to undergo the screening and submit documentary proof (an authenticated laboratory report) that they are tested negative for the Hepatitis B surface antigen.

Applicants who are HBsAg positive (regardless of HBeAg status) will NOT be allowed to proceed with the elective posting. The Hospital reserves the right to require any candidates to undergo further tests for any or all markers of the Hepatitis B virus.

Applicants who have been tested negative for HBsAg but are not immune (anti-HBs negative or < 10 mIU/mL) are required to be immunized prior to the start of the elective attachment applied for.

Applicants who are unable to acquire immunity after vaccinations (i.e. anti-HBs < 10 mIU/mL) will NOT be allowed to proceed with the elective posting.

Proof of Hepatitis C screening

Please attach documentary proof that you have been screened and tested negative for Hepatitis C. Students who are tested positive or not able to submit the documentary proof upon application, will not be allowed to proceed with the posting.

Proof of HIV screening

Please attach documentary proof that you have been screened and tested negative for HIV. Students who are tested positive or not able to submit the documentary proof upon application, will not be allowed to proceed with the posting.

Proof of Immunity to Varicella (Chickenpox)

Immunity to Chickenpox (Varicella Zoster) – Must provide official documentation of one of the following:

- Documentation from health care provider of a diagnosis of Chickenpox disease.
- Lab evidence of Varicella immunity (blood test)
- **Two** doses of Varicella vaccine.

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Proof of Immunity to Mumps, Measles and Rubella (MMR)

Please provide the following evidence for Mumps, Measles and Rubella (MMR).

Immunity to Measles — Must provide official documentation of one of the following:

- Documentation from health care provider of a diagnosis of measles disease
- Lab evidence of measles immunity (blood test)
- **Two** doses of live measles-containing vaccine on or after the 1st birthday

Immunity to Mumps — Must provide official documentation of one of the following:

- Documentation from health care provider of a diagnosis of mumps disease
- Lab evidence of mumps immunity (blood test)
- **Two** doses of live mumps-containing vaccine on or after the 1st birthday

Immunity to Rubella — Must provide official documentation of one of the following:

- Lab evidence of rubella immunity (blood test).
- One dose of live rubella-containing vaccine on or after the 1st birthday

Proof of Immunity to Tetanus/Diphtheria/Pertussis

Please attach documentary proof of vaccination with Tdap as an adult.

Those who have not previously received tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) should be vaccinated with a single dose of Tdap, regardless of the interval since the last dose of tetanus or diphtheria-containing vaccine.

Proof of Immunity to Influenza

Applicants are encouraged to receive the influenza vaccination.

~ Thank You ~