MEDICAL REPORT
FOR MALAYSIA MY SECOND HOME PROGRAMME

PERINGATAN
Reminder

BAHAGIAN II DAN II HENDAKLAH DIISI OLEH PEMOHON YANG BERKENAAN
Part I and II are to be completed by the applicant

1. BAHAGIAN I : BUTIR-BUTIR PERIBADI PEMOHON
Part I : Personal Particulars of Applicant

a) NAMA PENUH : .....
Full name: (DALAM HURUF BESAR / *IN CAPITAL LETTERS*)

b) NAMA LAIN (JIKA ADA) : .....
Other Name (if any) (DALAM HURUF BESAR / *IN CAPITAL LETTERS*)

c) JANTINA : .....
Gender:

d) NOMBOR PASPORT : .....
PassportNumber:

e) TARIKH DAN TEMPAT LAHIR : .....
Date and Place of Birth:

2. BAHAGIAN II : LATAR BELAKANG KESIHATAN
Part II : Medical History

a) ADAKAH ANDA PERNAH MENGHADAPI PENYAKIT BERIKUT?
Have you every suffered from the following ailments?

		YA *Yes*	**TIDAK** *No*	**JIKA YA, BERI ULASAN** *if yes, give brief details*
i.	**PENYAKIT OTAK** *Mental Illness*	☐	☐	
ii.	**BATUK KERING** *Tuberculosis*	☐	☐	
iii.	**SAWAN** *Epilepsy*	☐	☐	

		YA *Yes*	TIDAK *No*	JIKA YA, BERI ULASAN *if yes, give brief details*
iv.	**LELAH** *Chronic Asthma*	☐	☐	
v.	**HEPATITIS A / B**	☐	☐	
vi.	**AIDS**	☐	☐	
vii.	**KENCING MANIS** *Diabetes Mellitus*	☐	☐	
viii.	**PENYAKIT JANTUNG** *Heart Disease*	☐	☐	

b)	**RANGSANGAN** *Senses*	**BERFUNGSI** *Functioning*	**TIDAK BERFUNGSI** *Not Functioning*
i.	**RASA** *Taste*	☐	☐
ii.	**BAU** *Smell*	☐	☐
iii.	**SENTUHAN** *Touch*	☐	☐
iv.	**PENGLIHATAN** *Vision*	☐	☐
v.	**PENDENGARAN** *Hearing*	☐	☐

3. BAHAGIAN III : PENGESAHAN DOKTOR

Part III: Certification by Doctor

TO BE COMPLETED BY A REGISTERED DOCTOR

I have this day examined .....

Passport No. ..... and certify that:

i. He/ She is not suffering from any disease and is healthy. ☐

ii. He/ She is not very healthy but is not suffering from any contagious or infectious disease. ☐

iii. He / She is not healthy and is suffering from contagious or infectious disease which makes his/ her presence dangerous to the community. ☐

iv. He / She is not healthy and unfit for long distance travel, and chances of recovery is very slim. ☐

Signature and

Name of Doctor: .....

.....

Position Held: .....

Official Seal:

Dated this ..... day of ..... (month) ..... (year).