ދިވެހިރާއްޖެ ޙައްޖު ކޮޕަރޭޝަން ލިމިޓެޑް
MALDIVES HAJJ CORPORATION LIMITED
مؤسسة الحج المالديفية المحدودة

MEDICAL EXAMINATION FORM

1. Please fill in the form in English language.
2. Please write in CAPITAL LETTERS.
3. This form has 4 sections. Section 1 (Part A and B) is to be filled by the Haaji. Section 2, 3 and 4 is to be filled by the examining doctor from a Hospital Registered in the Maldives.
4. Haajis must submit medical examination results conducted within 60 days prior to the submission of the form to the Maldives Hajj Corporation Limited.

SECTION 1 (PART A) - To be completed by the Haaji

Full Name (as in National Identity Card)

_____

Passport No.

_____

National Identity Card No.

_____

Nationality

_____

Contact Number

_____

SECTION 1 (PART B) - Please tick (✓) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses.
* Immediate family refers to father, mother, brothers / sisters

NO	MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		IF "YES" PLEASE STATE
		YES	NO	YES	NO	
1	Fits, stroke, other neurological diseases					
2	Diabetes Mellitus					
3	Hypertension					
4	Heart or vascular diseases					
5	Asthma or any other long term respiratory diseases					
6	Kidney disease					
7	Cancer					
8	History of surgery					

NO	MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		IF "YES" PLEASE STATE
		YES	NO	YES	NO	
9	Other illnesses					

Current medication (Long term)

_____

_____

_____

I hereby certify that the information provided above is true and accurate. I acknowledge that providing false information may result in me being deemed unfit to travel.

Date _____ _____

Signature of the Haaji

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

1. BASIC MEASUREMENT	
Temperature:	Blood pressure (mmHg):
Pulse rate: (/ min)	SPO2:
2. GENERAL EXAMINATION	
Pallor Cyanosis Jaundice Oedema	

3. SYSTEMIC EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENTS
Cardiovascular system			
Respiratory System			
Abdomen / Hernia Orifices			
Nervous System			
Other systems (Please state the system which is abnormal in the comments with details)			

SECTION 3 - INVESTIGATIONS

URINE ANALYSIS		Date Taken
ITEM	Normal/abnormal	(if abnormal write the abnormal value)
Urine RE		

BLOOD TEST		Date Taken	
Hemoglobin/HCT:	TLC:	Neutrophil %:	Platelet:
Na/K :	Creat:	PT/INR:	AST/ALT:
Others:			

CHEST X-RAY and ECG INFORMATION	NORMAL	ABNORMAL	COMMENTS
Chest X-ray:			
ECG			

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR - Please tick (✓) in the relevant box

I certify that I have on this date ..... examined
Mr / Ms ..... ID No. .....
and found him / her :-

☐ Fit to travel

☐ Requires further investigation or follow-up to determine their fitness to travel. (Write details)

_____

_____

☐ Require wheelchair

Date _____ _____

Signature of Doctor and Official Stamp

Name of the Doctor (with Qualification) _____

Registration Number _____

Name of the Hospital _____