Pusat Kesihatan UiTM
Lot 1, Jalan Bijak 1/22, Seksyen1
Universiti Teknologi MARA (uiTM), 40450, Shah Alam
Selangor Darul Ehsan, Malaysia
Tel.: +603 5544 3630/3631/3833/2999
pusatkesihatan@uitm.edu.my

UNIVERSITI TEKNOLOGI MARA

Reference Number :
Date :

CERTIFICATION BY THE EXAMINATION DOCTOR

Name of Doctor **:** ……..

Qualification **:** ……..

Hospital / Clinic **:** ……..

Registration Number **:** ……..

To whom it may concern,

I hereby certify that Mr./Mrs. …… bearing Passport No. …… is deemed **medically fit** to study in Malaysia, in line with the mandatory guidelines regulated by the Ministry of Education (MOE), Malaysia.

…… ……

Signature of the Doctor **Date**

Official Stamp:

HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. Please read the instructions carefully before filling in the form.
2. Please fill in the form in English and in CAPITAL letters.

INSTRUCTIONS TO CLINIC

1. This form has 5 sections:
   A. Section 1 (PART A) to be filled by the student; and
   B. Section 1 (PART B), 2, 3, 4 and 5 to be filled by the examining doctor.
2. Please complete all required examination / tests mentioned in this form.

INSTRUCTIONS TO STUDENT

1. All applicants **shall** undergo health examination **within seven (7) working days** upon arrival in Malaysia.
2. Failure in complying with the above requirement will result in rejection of application for student pass.
3. Applicants are required to undergo health examination at approved Education Malaysia Global Services (EMGS) Panel Clinics / Health Centre of Public Universities.
4. In the event applicant fails the health examination, the student pass endorsement will not be processed and the applicant is required to leave Malaysia.
5. Applicants who fail their health examination may submit their appeal application **within three (3) working days** after receiving health examination result. Any application submitted after the stipulated period will not be entertained.
6. The Government of Malaysia reserves the right to reject any application:
   A. Based on the results of the health examination; and/or
   B. Should there be any evidence that applicant has given false information pertaining to the results of the health examination.

EDUCATION MALAYSIA GLOBAL SERVICES (986610-U)
Education Malaysia One-Stop-Centre, 20th Floor, Menara TA One, 22, Jalan P.Ramlee, 50250 Kuala Lumpur, Malaysia
Tel : +603 2782 5888 Fax: +603 2711 8533 Portal: www.educationmalaysia.gov.my

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 1 (PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMAIL ADDRESS

NATIONALITY

CONTACT NUMBER IN MALAYSIA

DATE OF BIRTH

AGE

SEX

MARITAL STATUS

INSTITUTE IN MALAYSIA

ACADEMIC YEAR

COURSE OF STUDY

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

The medical practitioner completing this form disclaims any and all liability to the fullest extent permitted by law for any personal injury, suffering or loss caused by any reliance on this information by any other party.

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 1 (PART B)

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 mother, brothers / sisters.

ITEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state details
	Yes	No	Yes	No	
1. Tuberculosis					
2. Hepatitis B					
3. Hepatitis C					
4. HIV					
5. Drugs use/abuse					
a. Opiates					
b. Methamphetamine					
c. Amphetamine					
d. Cannabinoids					
6. Congenital or Inherited Disorder					
7. 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 Diseases					
20. History of Blood Transfusion					
21. Other Illness:					

Current medication (Long Term)

VACCINATION HISTORY (where applicable)	Yes	No	Date of Vaccination
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 travellers coming from or transited more than 12 hours through countries with risk of Yellow Fever transmission.
2. All students are required to take vaccines as listed in numbers 2-7 above.
3. The students are required to bring along the International Certificate of Vaccination or Prophylaxis with them for verification of information.

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

TYPE OF APPLICATION

DATE OF MEDICAL SCREENING

EMGS REFERENCE NUMBER

1. BASIC MEASUREMENT

HEIGHT (m) :	WEIGHT (kg)	BMI(kg/m²)	PULSE RATE (PER MINUTE)	BLOOD PRESSURE: SYSTOLIC (mmHg)	BLOOD PRESSURE: DIASTOLIC (mmHg)

VISION TEST	NORMAL	DEFECTIVE
UNAIDED (L)		
UNAIDED (R)		
AIDED (L)		
AIDED (R)		

COLOR VISION TEST

COMMENT

HEARING ABILITY	NORMAL	DEFECTIVE
LEFT		
RIGHT		

COMMENT

2. GENERAL EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f . SKIN DISEASES			

3. SYSTEMIC EXAMINATION

ITEM	NORMAL	ABNORMAL	COMMENT
g. EYES (including funduscopy)			
h. EARS			
i. NOSE			
j. ORAL CAVITY / THROAT			
k. NECK			
l. CARDIOVASCULAR SYSTEM			
m. RESPIRATORY SYSTEM			
n. ABDOMEN/HERNIAL ORIFICES			
o. NERVOUS SYSTEM			
p. MUSCULOSKELETAL SYSTEM			

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 2 - PHYSICAL EXAMINATION (FOR EXAMINING DOCTOR)

4. MENTAL HEALTH ASSESSMENT

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A.	**General Appearance**	**Untidy**	**Neat & Tidy**
B.	**Speech Quality**	**No/Abnormal**	**Yes/Normal**
	Coherent		
	Relevant		
C.	**Mood**	**Yes/Abnormal**	**No/Normal**
	Depressed*		
	Anxious		
	Irritable		
D.	**Affect**	**Inappropriate**	**Appropriate**
E.	**Thought**	**Yes/Abnormal**	**No/Normal**
	Delusion		
	Suicidality*		
F.	**Perception**	**Yes/Abnormal**	**No/Normal**
	Hallucination		
G.	**Orientation**	**No/Abnormal**	**Yes/Normal**
	Time		
	Place		
	Person		

*Note: Refer to Questionnaire. If 'Abnormal' for any of item C, E, F or G, to certify as UNSUITABLE.

QUESTIONNAIRE

PART A: MOOD

		Yes/Abnormal	No/Normal
A.	During the past month, have you been feeling down/depressed for most of the days?		
B.	During the past month, have you lost interest in doing things that you like for most of the days?		

If 'Yes' to question A or B, to tick 'Abnormal' at DEPRESSED in assessment box.

PART B: SUICIDALITY

		Yes/Abnormal	No/Normal
C.	Do you feel that life is not worth living?		
D.	Do you have any thoughts about ending your life?		

If 'Yes' to question C or D, to tick 'Abnormal' at SUICIDALITY in assessment box.

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 3 - INVESTIGATIONS

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE OF LAB TEST

NAME OF LAB

URINE TEST

ITEM	POSITIVE	NEGATIVE	COMMENT
a. ALBUMIN			
b. SUGAR			
c. MICROSCOPIC EXAMINATION			
d. OPIATES (INCLUDING CODEINE, MORPHINE, HEROIN)			
e. CANNABINOIDS			
f. AMPHETAMINE TYPE STIMULANT			

BLOOD TEST

ITEM	POSITIVE / ABNORMAL	NEGATIVE / NORMAL	COMMENT
a. HEPATITIS Bs ANTIGEN			
b. HIV ANTIBODY			
c. HEPATITIS C ANTIBODY			
d. MALARIAL PARASITES			
e. VDRL			
f. TPHA*			

* TPHA is done if VDRL is reactive

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 4 - CHEST X-RAY INFORMATION

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NUMBER

EMGS REFERENCE NUMBER

DATE TAKEN

PLACE TAKEN

CHEST X-RAY NUMBER

COMMENT

ITEM	NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
a. THORACIC CAGE			
b. HEART SHAPE AND SIZE (CTR > 0.55 AND IN FAILURE OR SIGNIFICANT CARDIOMEGALY)			
c. LUNG FIELDS			
d. MEDIASTHNUM AND HILAR REGION			
e. PLEURA / HEMIDIAPHRAGMS / COSTOPHRENIC ANGLES			
f. FOCAL LESION			
g. ANY OTHER ABNORMALITIES			
h. IMPRESSION			

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENTS

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (/) the appropriate box

I certify that I have on this date _____ examined

Mr. / Ms. _____

Passport Number _____ and found him/her with the following disease/condition:

TYPE OF APPLICATION

EMGS REFERENCE NUMBER

ITEM		ABNORMAL
1.	Tuberculosis	
2.	Hepatitis B	
3.	Hepatitis C	
4.	HIV	
5.	Cancer	
6.	Epilepsy	
7.	Psychiatric Illness	
8.	Drugs	
	a. Opiates	
	b. Amphetamine/Methamphetamine	
	c. Cannabinoids	
9.	Malaria	
10.	Sexually Transmitted Disease	
11.	Others (Please Specify)	

HEREBY THE STUDENT IS CERTIFIED AS:

☐ SUITABLE ☐ UNSUITABLE

FOR STUDIES/COURSE IN MALAYSIA.

COMMENTS:

NAME OF DOCTOR

DATE

QUALIFICATION

HOSPITAL/CLINIC

REGISTRATION NUMBER