Medical Examination Report Form

**Heading:**

* **Institution's Logo**
* **Title: Medical Examination Report**

**Personal Information:**

* **Candidate Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Examination Reason: ☐ Employment ☐ Annual Checkup ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Examination:**

* **Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Eyesight: Left Eye: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Right Eye: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Hearing Test: ☐ Pass ☐ Fail**

**Laboratory Findings:**

* **Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Hemoglobin Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Urinalysis Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Assessor's Observations:**

* **Text Box for observations**

**Certification:**

* **I certify that the information above is accurate to the best of my knowledge.**
* **Physician's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**