



MEDICAL REPORT

for person applying to live temporarily in Samoa

This form is to be completed by a registered medical practitioner
after personally examining the applicant.

Attach a
passport-
sized
photo of the
applicant
here

PART A. TO BE COMPLETED BY THE APPLICANT BEFORE VISITING THE DOCTOR

1. Family name 2. Given name
3. Gender 4. Date of birth 5. Occupation

6. How long do you intend staying in Samoa?

7. Your medical history:

Have you ever had:

Please tick
YES or NO

If yes, provide details

- | | <input type="checkbox"/> | <input type="checkbox"/> | |
|---|--------------------------|--------------------------|----------------------|
| (a) an operation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (b) been admitted to hospital? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (c) have you previously suffered or
presently suffering from any
communicable diseases for more
than 2 weeks
eg. Tuberculosis other <input type="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (d) an abnormal x-ray? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (e) convulsions, fits or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (f) anxiety, depression or nervous
complaints requiring treatment/
Counselling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (g) high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (h) heart trouble, chest pains or
breathlessness? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (i) kidney or bladder disease or
complaint? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (j) any illness, injury or medical
condition lasting more than
2 weeks or a recurring
condition not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (k) are you taking any pills,
medicine or having any other
medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (l) have you ever been addicted
to a drug or taken drugs
illegally? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (m) do you consume alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (n) do you smoke, or have you
ever smoked tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| (o) Do you have a medical condition
that may require periodic
hospitalisation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

APPLICANT'S DECLARATION - to be signed in the presence of the examining doctor.

I declare that the information I have provided on this form is correct.

Signature

Date

PART B: EXAMINING DOCTOR'S FINDINGS

8. Height	<input type="text"/>	Weight	<input type="text"/>	Blood pressure	<input type="text"/>	BSL	<input type="text"/>
<div style="text-align: center;">Please tick</div> <div style="display: flex; justify-content: space-around;"> Normal or Abnormal Details </div>							
9. Cardiovascular system (record any evidence of heart murmurs, cardiac failure, irregularity or other heart abnormality)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
10. Respiratory system (for current or previous TB, provide date and duration of treatment and name, strength and dosage of drugs used)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
11. Nervous system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
12. Mental state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
13. Gastrointestinal system including hernia orifices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
14. Locomotor system/physical build/mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
15. Skin and lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
16. Endocrine system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
17. Ear/nose/throat/mouth/teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
18. Hearing							
	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>			
19. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
20. VDRL test result - only in clinically indicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
<div style="text-align: center;">Please tick</div> <div style="display: flex; justify-content: space-around;"> Positive or Negative Details </div>							
21. Hepatitis B antigen test result	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
22. Human Immunodeficiency Virus test result: please repeat and perform Western Blot test. (Pre-test and post-test counselling for positive results is mandatory).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>				
23. Urinalysis:	Blood	<input type="text"/>	Albumin	<input type="text"/>	Sugar	<input type="text"/>	
24. Stool Culture	<input type="text"/>	mandatory for people coming to Samoa as food handlers and teachers					

DOCTOR'S CONCLUSIONS: Please consider the information you have provided about this applicant. Please consider if the applicant has the potential to be a health risk in Samoa or a financial burden to Samoa. Please tick the appropriate box:

☐
☐
☐

No significant history or abnormal findings present

Significant history or abnormal findings present - please attach details

Subject to following condition:

Doctor's signature

Doctor's Full Name

Contact phone

Date