

PRIORITY NO.
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**USE PASSPORT INFORMATION**

Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Middle Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Birth date with year: \_\_\_\_\_  
 Civil Status: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Embassy:  Canada  Australia  New Zealand  
 Visa Type / Category:  Temporary  Permanent

Height in meters: \_\_\_\_\_  
 Weight in Kg: \_\_\_\_\_  
 BMI: \_\_\_\_\_

**EYE TEST:**

<u>Uncorrected</u>	<u>Corrected</u>
OS	_____
OD	_____

**MEDICAL EXAMINATION FLOW**

I. REGISTRATION
II. PRE-EXAM
III. CASHIER
IV. URINE COLLECTION
V. BLOOD EXTRACTION
VI. CHEST X-RAY
VII. PHYSICAL EXAMINATION

Passport Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Date of Expiry: \_\_\_\_\_

(If Passport is not applicable) Other Valid ID: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

**PREFERRED PHILIPPINE CONTACT NUMBER AND ADDRESS:**

Mobile Number: \_\_\_\_\_ / \_\_\_\_\_ Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Permanent Philippine Address: \_\_\_\_\_

**DECLARATION BY EXAMINEE**

- \_\_\_\_\_ 1. I declare that the person named in BOX 1 above has never had a previous medical examination ANYWHERE as part of an embassy's visa or Immigration requirement (Do not sign if the person named had a prior medical evaluation for visa of Immigration purpose).
- \_\_\_\_\_ 2. I declare that the information given above are TRUE and CORRECT.

\_\_\_\_\_  
 Signature over Printed Name

PERTINENT HISTORY OR PHYSICAL EXAMINATION:

ADDITIONAL TEST/S:	CXR RESULT / NOTES:
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RECOMMENDATION / COMMENTS: