



I'm not robot



Next

CONFIDENTIAL MEDICAL REPORT

NAME:.....REG.No:.....

SECTION I. To be filled by applicant with the help of a nurse or examining physicians, if necessary.

A. Have you ever suffered from or been advised that you have: (Underline Yes/No, where applicable)

- | | | |
|-------------------------------------------|-----|----|
| 1. Fits/Convulsion or Fainting Spells | Yes | No |
| 2. Depression or any other mental illness | Yes | No |
| 3. Anaemia | Yes | No |
| 4. Sickle Cell Disease | Yes | No |
| 5. Jaundice | Yes | No |
| 6. Tuberculosis | Yes | No |
| 7. Bronchitis | Yes | No |
| 8. Pneumonia | Yes | No |
| 9. Peptic Ulcer | Yes | No |
| 10. Colitis | Yes | No |
| 11. High Blood Pressure | Yes | No |
| 12. Diabetic mellitus | Yes | No |
| 13. Yaws | Yes | No |
| 14. Leprosy | Yes | No |
| 15. Gonorrhoea | Yes | No |
| 16. Syphilis | Yes | No |
| 17. Drug or Alcohol problem | Yes | No |
| 18. Asthma | Yes | No |
| 19. Other Allergies | Yes | No |
| 20. Chickens Pox | Yes | No |
| 21. Typhoid Fever (Enteric fever) | Yes | No |

B. Have you ever been admitted to a Hospital, Health Centre or Clinic? Yes/No,

C. In the case of a female applicant:

- i. State the date of your Last Menstrual Period (LMP)
- ii. Have you ever had any Obstetric or Gynaecological problem or operation? Yes/No

D. If the answer to any of the questions is "Yes", please give details below.

Disease or Injury	Date	Duration	Name & Address of Doctor or Hospital

E. Family Record:

Has any member of your family ever had:-

- | | | | | | |
|-----------------|-----|----|-----------------------------------|-----|----|
| Tuberculosis | Yes | No | Myocardial Infarct (Heart Attack) | Yes | No |
| Asthma | Yes | No | Cancer | Yes | No |
| Epilepsy | Yes | No | Sickle Cell disease | Yes | No |
| Mental Disorder | Yes | No | Obesity | Yes | No |
| Hypertension | Yes | No | Allergic Condition(s) | Yes | No |
| Stroke | Yes | No | G.6 PD - Deficiency | Yes | No |

F. Declaration:

I..... declare that the foregoing answers are true and that no pertinent aspect of my medical history has been withheld.

Name of Witness:..... Signature of Applicant:.....
Signature of Witness:..... Date:.....

MVD-10124
REV. 05/15



NEW MEXICO TAXATION & REVENUE DEPARTMENT, MOTOR VEHICLE DIVISION



MEDICAL REPORT

Please be advised that the decision to allow an applicant to continue to retain his/her New Mexico driver's license is contingent upon the information provided in this medical report. It is imperative, and in the best interest of the applicant and the motoring public, that all questions be answered completely. This report may be reviewed by a physician or panel of physicians, who may request additional medical information. This form will become part of the applicant's record, is for confidential use of the physician, panel or division, and may not be divulged to any person or used as evidence in any trial.

Medical Advisory Board Use Only

- Approved
 Denied

ALL INFORMATION MUST BE TYPED OR CLEARLY PRINTED

Applicant Information

Applicant's Name (Last, First, Middle Initial)		Date of Birth	
Mailing Address		City, State ZIP Code	
Telephone Number	E-mail Address	Social Security Number	Driver's License Number

Physician's Report

1. DISEASE or CONDITION - **Note:** a) Provide details in #3 below for **any** box checked.

<input type="checkbox"/> Neurological	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Psychological	<input type="checkbox"/> Dementia	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Orthopedic/Prosthetic
<input type="checkbox"/> Other:		
2. How long have you treated this patient? Frequency? Date of last examination
3. Describe the nature, extent and frequency of any of the patient's symptoms, especially those that might affect the safe operation of a motor vehicle.
4. Diagnoses (list): Treatment (medical/surgical/device):
5. List the kind, quantity and frequency of any medication with which the patient is being treated.

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS		
For use of this form, see AR 600-8-4, the proponent agency is DCS, G-1.		
THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code)
1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
4. ORGANIZATION AND STATION		5. ACCIDENT INFORMATION
		a. DATE
		b. PLACE (City and State)
SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR		
6. INDIVIDUAL WAS <input type="checkbox"/> OUT PATIENT <input type="checkbox"/> ADMITTED <input type="checkbox"/> DEAD ON ARRIVAL	7. NAME OF HOSPITAL OR TREATMENT FACILITY <input type="checkbox"/> CIVILIAN <input type="checkbox"/> MILITARY	
8. HOUR AND DATE ADMITTED	9. HOUR AND DATE EXAMINED	
10. NATURE AND EXTENT OF <input type="checkbox"/> INJURY <input type="checkbox"/> DISEASE <input type="checkbox"/> RESULTING IN DEATH		
11. MEDICAL OPINION: a. INDIVIDUAL <input type="checkbox"/> WAS <input type="checkbox"/> WAS NOT UNDER THE INFLUENCE OF <input type="checkbox"/> ALCOHOL <input type="checkbox"/> DRUGS (Specify). b. INDIVIDUAL <input type="checkbox"/> WAS <input type="checkbox"/> WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate). c. INJURY <input type="checkbox"/> IS <input type="checkbox"/> IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE. d. INJURY <input type="checkbox"/> WAS <input type="checkbox"/> WAS NOT INCURRED IN LINE OF DUTY. BASIS FOR OPINION:		
12. THE FOLLOWING DISABILITY MAY RESULT <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT PARTIAL <input type="checkbox"/> PERMANENT TOTAL	13. BLOOD ALCOHOL TEST MADE <input type="checkbox"/> YES <input type="checkbox"/> NO	14. NO. OF MG ALCOHOL/100 ML BLOOD
15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (How, where, when)		
16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE
SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER		
19. DUTY STATION <input type="checkbox"/> PRESENT FOR DUTY <input type="checkbox"/> ABSENT WITHOUT AUTHORITY <input type="checkbox"/> ABSENT WITH AUTHORITY <input type="checkbox"/> ON PASS <input type="checkbox"/> ON LEAVE		20. HOUR AND DATE OF ABSENCE a. FROM b. TO
21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance) <input type="checkbox"/> YES <input type="checkbox"/> NO		
22. INDIVIDUAL WAS ON <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> ACTIVE DUTY FOR TRAINING <input type="checkbox"/> INACTIVE DUTY TRAINING		23. HOUR AND DATE TRAINING a. BEGAN b. ENDED
24. RESERVIST DIED OF INJURIES RECEIVED PROCEEDING <input type="checkbox"/> DIRECTLY TO TRAINING <input type="checkbox"/> DIRECTLY FROM TRAINING		
25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED
		28. NORMAL TIME FOR TRAVEL
29. DUTY STATUS AT TIME OF DEATH IF DIFFERENT FROM TIME OF INJURY OR CONTRACTION OF DISEASE <input type="checkbox"/> PRESENT FOR DUTY <input type="checkbox"/> ABSENT WITH AUTHORITY <input type="checkbox"/> ABSENT WITHOUT AUTHORITY		
30. DETAILS OF ACCIDENT - REMARKS (If additional space is needed, continue on reverse) (Attach inclosures as necessary)		
31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO		32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) <input type="checkbox"/> YES <input type="checkbox"/> NO
33. DATE	34. TYPED NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE

DA FORM 2173, OCT 72 REPLACES DA FORM 2173, 1 JUN 66, WHICH IS OBSOLETE. AFD V2.01

MULTI-PURPOSE INSURANS BHD

Head Office: 8th Floor, Menara Multi-Purpose, Damansara, 8 Jalan Masjid Aman, 50460 Kuala Lumpur
Tel: 03-2033 8888 Fax: 03-2033 8888 P.O. Box 101, 50000 Kuala Lumpur

DISCHARGE MEDICAL REPORT FORM

5

SECTION I - To be completed by the insured / Claimant (ENGLISH VERSION)		SEKSYEN I - Untuk diisi oleh Insurans / Pihak Insurans (MELAYU BERSAMA)	
Name / Nama (No. EP)		Policy No. / No. Polisi	
Claimant (other than the insured) / Pihak Insurans (bukan tertanggung)		NICK No. / No. NCK (if applicable) / (jika berkuatkuasa)	
<input type="checkbox"/> Self / Sendiri <input type="checkbox"/> Spouse / Pasangan <input type="checkbox"/> Child / Anak		<input type="checkbox"/> Self / Sendiri <input type="checkbox"/> Spouse / Pasangan <input type="checkbox"/> Child / Anak	
Date of Birth / Tarikh Lahir (MM / DD / YY)		Date of Birth / Tarikh Lahir (MM / DD / YY)	
Sex / Jenis Kelamin (Male / Female) / (Laki / Perempuan)		Sex / Jenis Kelamin (Male / Female) / (Laki / Perempuan)	
Employer Name / Nama Perusahaan		Employer Name / Nama Perusahaan	
Address / Alamat		Address / Alamat	
Date of Incident / Tarikh Kejadian		Date of Incident / Tarikh Kejadian	
Type of Claim / Jenis tuntutan (Please tick where applicable) / (Tanda di mana yang berkuatkuasa)		Type of Claim / Jenis tuntutan (Please tick where applicable) / (Tanda di mana yang berkuatkuasa)	
<input type="checkbox"/> Hospitalized / Ditinggalkan di hospital <input type="checkbox"/> Disposition / Disposisi <input type="checkbox"/> Accident / Kemalangan		<input type="checkbox"/> Hospitalized / Ditinggalkan di hospital <input type="checkbox"/> Disposition / Disposisi <input type="checkbox"/> Accident / Kemalangan	
If injuries are due to accident, please describe how the accident occurred / Jika berkuatkuasa disebabkan oleh kemalangan, sila terangkan bagaimana kemalangan berlaku.			
Details of other insurances / Details of other insurances and others (Please use a separate sheet if necessary) / Butiran insurans lain / Butiran insurans dan yang lain (Silakan gunakan satu lembaran berasingan jika perlu)			
Policy Type / Jenis Polisi		Policy Type / Jenis Polisi	
Period of Cover / Tempoh Berkuatkuasa		Period of Cover / Tempoh Berkuatkuasa	
Insurer / Insurans		Insurer / Insurans	
Policy No. / No. Polisi		Policy No. / No. Polisi	
AUTHORIZATION TO PHYSICIAN, HOSPITAL OR CLINIC TO RELEASE INFORMATION & DOCUMENTS / IZIN KEPADA DOKTER, HOSPITAL ATAU KLINIK UNTUK MENYEDIAKAN MAKLUMAT DAN DOKUMEN			
I hereby authorize my physician, medical practitioner, hospital or clinic to release to whom I authorize such release to be made, to give full particulars about my/our health including my/our medical history in respect of the hospitalization/hospitalization, to the above insurance company. / Saya izinkan kepada doktor/ahli perubatan/ hospital/ klinik yang mana sahaja yang berkekuasaan untuk memberikan maklumat mengenai kesihatan saya/ kami termasuk sejarah perubatan saya/ kami mengenai rawatan di hospital/ klinik/ klinik tersebut kepada syarikat insurans di atas.			
Signature of Insured / Tandatangan Insurans		Signature of Insured / Tandatangan Insurans	
Date / Tarikh		Date / Tarikh	

Family Health Administration Medical Report Form 202

The Family Health Administration is committed to providing services to the community and to the people of the state. We are committed to providing services to the community and to the people of the state. We are committed to providing services to the community and to the people of the state.

Name of Patient: _____ Date of Birth: _____

Address: _____

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ Date: _____

Signature of Nurse: _____ Date: _____

Signature of Pharmacist: _____ Date: _____

Signature of Physiotherapist: _____ Date: _____

Signature of Occupational Therapist: _____ Date: _____

Signature of Speech Therapist: _____ Date: _____

Signature of Dietitian: _____ Date: _____

Signature of Social Worker: _____ Date: _____

Signature of Psychologist: _____ Date: _____

Signature of Psychiatrist: _____ Date: _____

Signature of Podiatrist: _____ Date: _____

Signature of Optician: _____ Date: _____

Signature of Audiologist: _____ Date: _____

Signature of Physiotherapist: _____ Date: _____

Signature of Occupational Therapist: _____ Date: _____

Signature of Speech Therapist: _____ Date: _____

Signature of Dietitian: _____ Date: _____

Signature of Social Worker: _____ Date: _____

Signature of Psychologist: _____ Date: _____

Signature of Psychiatrist: _____ Date: _____

Signature of Podiatrist: _____ Date: _____

Signature of Optician: _____ Date: _____

Signature of Audiologist: _____ Date: _____

How to check dha medical report online. Gcc medical report online check near dhaka. How to get medical report from dha. How to get visa medical report online in abu dhabi. Passport medical report check online near dhaka. Medical report check online near dhaka. Gamca medical report check online dhaka. How to download dha medical report online.

Skip to Content Home à €™ DHA Exam Application Tención Processing and registration In Dubai, UAE, the DHA exam is a national examination for professional health licenses. This examination is administered by the Dubai Health Authority (DHA) that also manages the professional license of medical professionals and supervises the general health system in Dubai. The DHA intends to provide and maintain an accessible, efficient and integrated health system within the Emirate. However, there are different sets of application requirements for the DHA examination application based on the professional qualification requirements of the candidate or PQR that varies by profession. How request the online DHA exam? The standard DHA exam request for foreign health candidates consists of the following steps: Step 1: DHA preeligibility and data flow Application phase Application Pre eligibility and data flow or verification of primary sources (PSV) It is the phase in which the candidate can determine if they are eligible for the category that the candidate requested, mainly based on their training and professional training. Once the candidate determines that they are qualified to proceed in the DHA examination request process, the candidate must undergo a highly reliable background detection procedure to verify the personal or professional credentials of the candidate directly from his source of Original emission DHA DataFlow requirements vary depending on the candidate's profession. Therefore, make sure that the information you will provide in your application is correct. Any discrepancy can raise a red flag. Two states of application DHA or results can show in a candidate data flow report: a positive or negative result. Each candidate who sent their documents for the verification process will receive a dedicated data flow reference number DHA and details as your reference. Step 2: dha-phase review planning the dha-testing and programming phase is pre present confirmation of the candidate DHA exam program. In this phase, you must prepare for DHA exam questions you can find in your exam and study the DHA exam pattern to be prepared. If you have not taken advantage of a review course, this is the time to do so. Step 3: Take the DHA exam on your exam, make sure to bring acceptable forms of identification and plan to reach the test center at least 45 minutes of your test time confirmed for guidance and verification of proposals. If you are late or reaches the test center without acceptable identification, you will be returned and you can register again for exam scheduling. You will also have to pay again for another DHA exam fee. Step 4: Claim your DHA Result Candidates can access the results of their official exams using the corresponding DHA Sesión Start data that has been given. There are two DHA exam results, either pass or fail only. There will be no examination scores, or exam certificates issued regardless of whether the candidate passed or failed the exam. Step 5: DHA Prof Credentialing Evaluation Phase Once the candidate received his Dataflow report and approved the exam, the candidate can now proceed to the Prof Credentialing evaluation phase. This is the process in which the candidate's eligibility letter will be published; This document is necessary to process your DHA license. Take note, to process your license application, you must find an employer first if you have not done so yet, you can link your request with the DHA regulator body for DHA license expedition. Since the search for the application requirements for the DHA exam and other qualifications may be overwhelming, especially for foreign health candidates who do not know or have no knowledge in the application for the DHA exam. Due to this application process for For DHA, candidates are advised to seek assistance from a specialized application preparation center as Neac Medical Exams Center. Neac is a one Center for the application of pioneer medical examinations that offers easy and fast examination applications for DHA and will do all the work for your DHA application for the best price to avoid financial losses and delays that can cause a Diploma of Teachers in Dussia (man) are not exempt in the exam and even are obliged to take and approve the DHA exam. Is there are qualifying scores or grades written on the result of a candidate DHA exam? There are two results of DHA exams, they only pass or just fail. There will be no exam scores, or examination certificates issued, regardless of whether the candidate passed or failed the exam. Choose a result of a selection on a full update page. Press the space key and then the arrow keys to make a selection. Selection. 2 d. geleiden - The Dubai Health Authority (DHA) was created, in June 2007, by Law 13 issued by His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE, Ruler of Dubai, with an expanded vision to include strategic oversight for the complete health sector in Dubai and enhance private sector engagement. His Highness Sheikh Hamdan ... The Dubai Health Authority (DHA) was created, in June 2007, by Law 13 issued by His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE, Ruler of Dubai, with an expanded vision to include strategic oversight for the complete health sector in Dubai and enhance private sector engagement. His Highness Sheikh Hamdan Bin Rashid Al ... The DHA is custodian, protector and verifier of the identity and status of citizens and other persons resident in South Africa. This makes it possible for people to realize their rights and access benefits and opportunities in both the public and private domains. By expanding these services to marginalized communities, the department plays is a key enabler in deepening ... DHA Medical Fitness Application

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