Workaway International

2018

GENERAL PRACTITIONER RECOMMENDATION

I certify that I have examined and medically evaluated Mr/s ______________________________
in accordance with Workaway International procedures.

☐ Approved and in good physical condition and able to perform work required for employment in the service industry

☐ Not Approved (Reason)
____

Dr ______________________ **Contact Number:** ______________________

Address: ______________________
______________________ **Signature:** ______________________
____
______________________ **Date:** ______________________
____

HPCSA Number: ______________________

MMI HEALTH USE ONLY		
Approved	**Not Approved**	**Reason for Non Approval**
Signature: ______	**Signature:** ______	
Date: ______	**Date:** ______	

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TEST RESULTS

In the event that a patient tests positive for one of the tests below, a re-test can be done in a couple of days, at the patient's own account.

Results 1

BLOOD TEST RESULTS

	Pos	Neg
Hepatitis A		
Hepatitis B		
Hepatitis C		

Pathology Results included | Yes | No |

RADIOLOGY RESULTS

Clear	
Other	

DRUG TEST RESULTS

	Pos	Neg		Pos	Neg
Cocaine			Amphetamines		
Marijuana			Methamphetamines		
Heroine					

Comments: ______________________________

Results 2

BLOOD TEST RESULTS

	Pos	Neg
Hepatitis A		
Hepatitis B		
Hepatitis C		

Pathology Results included | Yes | No |

RADIOLOGY RESULTS

Clear	
Other	

DRUG TEST RESULTS

	Pos	Neg		Pos	Neg
Cocaine			Amphetamines		
Marijuana			Methamphetamines		
Heroine					

Comments: ______________________________

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DECLARATION OF CONSENT TO MEDICAL EVALUATION AND TESTS

I, ______________________________

Hereinafter referred to as "The Applicant"

Identity Number/Passport Number ______________________________

Declare the following:

That the medical evaluation and the tests that will be performed have been explained to me;

That I fully understand the explanation of the evaluation and the tests that will be performed;

That I hereby give informed consent to the doctor or any other person nominated to the doctor to perform all the tests and to take a sample of urine for these purposes.

I further hereby give informed consent to the doctor to submit my tests results to Workaway International.

Furthermore, I hereby indemnify the doctor, his/her employees and MMI Health and its directors, agents and employees against any claim of whatever nature instituted by myself or on my behalf, or against any claim by any third party which may arise as a result of any test done, the consultation, the medical examination or the results of the tests performed, with regard to the medical examination undertaken.

In the event of any of the results proving positive, I request and consent that the following be informed of the positive result:

Name of doctor: ______________________________

Address of doctor: ______________________________

Signed: ______________________________

Date: ______________________________

Applicant signature: ______________________________

Identity number: ______________________________

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CONFIDENTIAL MEDICAL REPORT

WORKAWAY INTERNATIONAL MEDICAL EVALUATION

DETAILS OF APPLICANT

SURNAME ________________ NAME ________________

ADDRESS ________________

DATE OF BIRTH [DDMMCCYY] ID No. ________ Passport No. ________

GENDER [M] [F] Signature of doctor confirming identification of applicant: ________________

MEDICAL HISTORY

ARE YOU OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING

HEART DISEASE		
Rheumatic Fever	Yes	No
High Blood Pressure	Yes	No
Other Heart Conditions	Yes	No

DISEASE OF THE INTESTINAL TRACT		
Gastric or Duodenal Ulcer	Yes	No
Chronic Diarrhoea	Yes	No
Jaundice	Yes	No

DISEASE OF THE RESPIROTORY SYSTEM		
Tuberculosis	Yes	No
Asthma	Yes	No
Chronic Bronchitis	Yes	No
Allergic Rhinitis (Hay Fever)	Yes	No
Recurrent Sinusitus	Yes	No
Do you smoke	Yes	No

PSYCHIATRIC / MENTAL / BEHAVIOURAL DISORDERS		
Depression	Yes	No
General Anxiety / Panic Attacks	Yes	No
Phobias	Yes	No
Schizophrenia / Bipolar	Yes	No
Any Drug or Alcohol Dependency	Yes	No

BACK AND ORTHOPAEDIC PROBLEMS		
Chronic Back/Neck/Knee Pain	Yes	No
Back/Neck/Knee Injury	Yes	No
Disc Prolaps	Yes	No
Arthritis	Yes	No

DISEASE OF THE REPRODUCTIVE /URINARY SYSTEM		
Kidney Stones	Yes	No
Sexually Transmitted Disease	Yes	No
HIV/HIV Related Disease	Yes	No

DISEASE OF THE NERVOUS SYSTEM		
Epilepsy	Yes	No
Recurrent Bouts of Syncope	Yes	No
Seizures	Yes	No
Other	Yes	No

HORMONAL IMBALANCES		
Diabetes Mellitus	Yes	No
Thyroid Problems	Yes	No
Other	Yes	No

DISEASES OF THE NEUROLOGICAL SYSTEM		
Head/Brain Injuries/Illness	Yes	No
Headaches	Yes	No
Paralysis/Numbness	Yes	No
Other	Yes	No

CANCER		
Have you been treated for any form of cancer?	Yes	No
Re-treatment for any form of cancer	Yes	No
Growth tumor of any kind	Yes	No
Currently on treatment?	Yes	No

EYE CONDITION		
Compromised Eyesight (except glasses/contacts)	Yes	No

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MMI HOLDINGS

DISEASE OF THE SKIN		
Chronic Eczema	Yes	No
Psoriasis	Yes	No
Other	Yes	No

EAR CONDITIONS		
Impairment of hearing	Yes	No
Any other chronic ear condition	Yes	No

Details of any of above questions answered yes - indicate period/time last treated

ALLERGIES

Are you allergic (Contact, Systematic, Food, Medicine, Chemicals or Antibiotics) Yes | No

Details ______________________

MEDICATION (List any current or other long-term medication, sedatives or tranquilizers used during the past 3 years)

PREVIOUS ILLNESSES, INJURIES AND OPERATIONS NOT YET LISTED. IS THERE A HISTORY OF ANY FAMILY OR OTHER DISEASE NOT YET MENTIONED? i.e. PORPHYRIA

FEMALES

Are you pregnant?	Yes	No	
Last Menstrual Period	DAY	MONTH	YEAR

DETAILS OF FAMILY DOCTOR

Dr name: ______________________ Tel: ______________________

Address: ______________________

I declare that this statement on my health status is a true reflection and gives permission to my personal Family Doctor to release any relevant medical information if requested to assist in the consideration of this application.

Date ______________ Signature ______________

EXAMINATION

Weight ______________ Height ______________ BMI ______________

RESPIRATORY SYSTEM

Chest ______________

Peak Flow ______________ L/M

Chest X-Ray Results ______________

CARDIOVASCULAR SYSTEM

Blood Pressure ______________ Pulse ______________

Any signs of Cardiovascular disease Yes | No

GASTRO-INTESTINAL TRACT

Any signs of disease with special reference to hepatitis? Yes | No

CENTRAL NERVOUS SYSTEM

Describe any abnormality ______________

EYES

Is the eyesight good Yes | No

DERMATOLOGICAL SYSTEM

Is the skin healthy? Yes | No

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MMI HOLDINGS

EARS, NOSE and THROAT

Any signs of disease of ears, nose or throat? | Yes | No |

URO-GENITALS SYSTEM (Describe any abnormality)

URINE: Protein ______________________ Blood ______________________

Bilirubin ______________________ Urobilinogen ______________________

HCG Qualitive Pregnancy Test | Pos | Neg |

LOCOMOTOR SYSTEM

Any signs of problems with cervical or lumber spine | Yes | No |

Any indication of active arthritis | Yes | No |

Any other impairment? ____

____

____

Are you satisfied that this applicant does not pose any risk from employment in the hospitality industry/food handling?

| Yes | No | ____

____

Do you recommend the request of any special investigation?

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