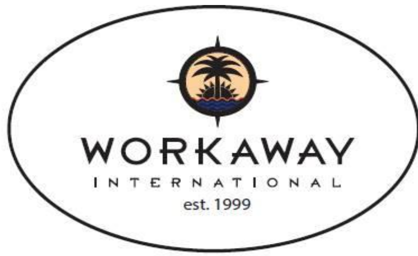
Workaway International

2019



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:** ____________	

Workaway International

2019

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: ____

Workaway International

2019

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: ______________________________

Workaway International

2019

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

Workaway International

2019

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

Provide details if you have answered yes to any of the above questions - 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

Workaway International

2019

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?

____

____

____

____

____

____

____

____

____

____