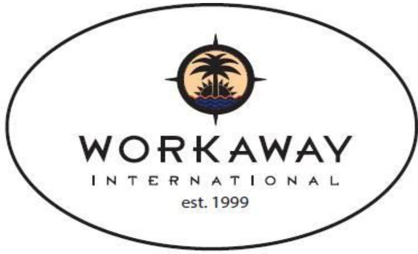


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## GENERAL PRACTITIONER RECOMMENDATION

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:** ______________________

| MOMENTUM HEALTH SOLUTIONS USE ONLY | | |
|---|---|---|
| **Approved** | **Not Approved** | **Reason for Non Approval** |
| | | |
| **Signature:** ____________ | **Signature:** ____________ | |
| **Date:** ____________ | **Date:** ____________ | |
| | | |

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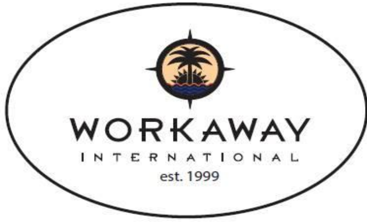


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## TEST RESULTS

*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 |

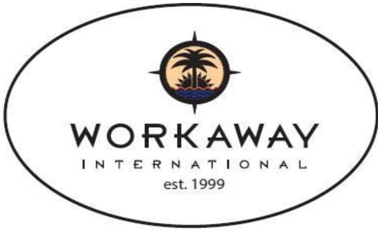
**RADIOLOGY RESULTS**

| | |
|---|---|
| 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 Momentum Health Solutions 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: ______________________________

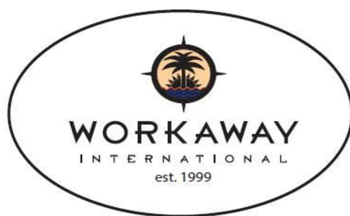
Address of doctor: ______________________________

______________________________

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 |

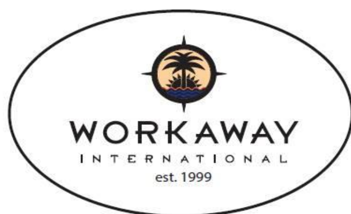
| DISEASE OF THE NERVOUS SYSTEM | | |
|---|---|---|
| Epilepsy | Yes | No |
| Recurrent Bouts of Syncope | Yes | No |
| Seizures | Yes | No |
| Other | Yes | No |

| 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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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

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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 Qualitative 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?