



WORKAWAY INTERNATIONAL

Employee Medical History

To be completed by all new hires and returners

Full Name _____ D.O.B. _____ Phone: _____
Address _____ Passport no. _____
Position: _____ Country Club: _____

Do you have or you ever had any of the following conditions?

CONDITION	YES	NO	CONDITION	YES	NO
Eye/Vision problems			Reproductive/Urinary disease		
Loss of Hearing			Kidney stones		
Allergies			Sexually transmitted disease		
Skin disorders			HIV Infection		
Eczema			HIV related disease		
Psoriasis			Other		
Other			Hormonal Imbalances		
Heart problems			Diabetes		
Rheumatic fever			Thyroid problems		
High blood pressure			Other		
Other			Disease of Nervous system		
Respiratory System problems			Epilepsy		
Tuberculosis			Recurrent bouts of syncope		
Asthma			Psychiatric disease:		
Chronic bronchitis			Depression		
Allergic rhinitis			General anxiety		
Back and orthopaedic			Panic attacks		
Chronic backache			Schizophrenia		
Chronic neck pain			Drug/Alcohol dependency		
Back injuries			Other		
Neck injuries			Cancer		
Disc prolaps			Cancer treatment		
Arthritis			Medication		
Other			Chronic		
Disease of the intestinal tract:			Current		
Ulcers (gastric/duodenal)			Any other illness		
Chronic diarrhoea			Any Operations		
Jaundice			Family History		
Other			Illness		
			Operations		

Do you currently have any medical problems (in addition to the above mentioned ones)? YES NO

Have you ever been declared medically unfit for work? YES NO

For Females only:

Are you currently pregnant? YES NO

How many pregnancies have you had? _____ How many children you have: _____

Last Menstrual Period: _____

If any of the above questions were answered „yes”, please give details below:

I certify that the above medical information is true and correct. Further, I give my consent to release my test results to authorized Resort management for appropriate review, and authorize the Resort and its representatives to use the test results as a defense to any legal action to which I am a party.

Applicant Signature.....

Date.....

Witnessed by

Date.....



WORKAWAY INTERNATIONAL

Employee Physical Examination

To be completed by physician. Circle and check all that applies

Full Name _____ D.O.B. _____ Phone: _____

Height: _____ Weight: _____ Body Mass Index: _____ Blood Pressure: L _____ R _____ Pulse: _____

	Normal	Abnormal		Normal	Abnormal
Eye Vision			Varicose Veins		
Ear			Gastrointestinal Tract		
Nose			Endocryn System		
Throat			Uro-Genital System		
Dental			Skin		
Respiratory System			Central Nervous System		
Cardiovascular Sysyem			Locomor System		
Laboratory tests	Normal	Abnormal	Laboratory tests	Normal	Abnormal
CBC			HIV		
Blood Glucose			TPHA		
SGOT/SGPT			Hepatitis A		
Urinalysis			Hepatitis B		
Stool Analysis			Hepatitis C		

Functions/Problems to be checked when examining:

- ENT (ear, Nose, Throat): Loss of Hearing; Otitis; Epistaxis; Nassal polypsl Septal deviation; Tonsillis, Tumors/Masses
- Dental: Cavities; Good Hygiene; Gingivitis
- Respiratory System: Constant cough; Sputum productions; Wheezing; Rhonchi
- Cardiovascular System: Palpitations; Chest pain; Murmurs; Gallops; Hypertension; Cardiomegaly; Dyspnea on exertion; Pedal edema; Arrhythmia
- Gastrointestinal Tract: Abdominal Pains; Diarrhoea; Constipation; Hemorrhoids; Hepatomegaly; Nausea
- Endocrine System: Diabetes; Thyroid problems
- Uro-Genital System: Pain on Urination; Hematuria; Veneral warts
 - Males: Varicocele; Scrotal Hernia
 - Females: Dysmenorrhrea; Birth control
- Skin Disorders: Lesions; Scars; Birthmarks; Jaundice; Discolorations; Eczema; Psoriasis; Tatoos
- Central Nervous System: Cranial Nerves (1-12); Peripheral Nerves; Anxiety; Depression; Hallucinations; Tremors; Vertije
- Locomotor System: Arthritis; Cervical Spine problems; Lumbar Spine Problems
- Paraclinicallinvestigation: EKG, Chest X-Ray, Lumbar Spine X-Ray (upon examining physician's request)

Please document and comment on all abnormal/positive test results and physical findings in the space provided below

Based on the clinical and paraclinical evaluation and tests, I declare Mr./Mrs. _____
Fit/Unfit for duty (circle one)

Physician's Stamp

Physician's Printed Name: _____

Physician's Signature: _____

Date of Examination: _____