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**PRE-EMPLOYMENT MEDICAL REPORT FORM FOR  
STUDENT CARE CENTRE (SCC) STAFF**

**I. NOTES TO EMPLOYER**

All Student Care Centres (SCCs) registered by the Ministry of Social and Family Development (MSF) as administrators of student care subsidies, must ensure that their staff undergo medical checks to determine they are fit for employment in a SCC. Please arrange for new staff to undergo the medical examination as outlined below and keep a copy of this report as well as other necessary documents for verification purposes.

**II. NECESSARY MEDICAL TESTS:**

- a) Physical examination
- b) Chest X-ray. Please attach a copy of the chest X-ray report to this form

**III. CERTIFICATION BY EXAMINING DOCTOR**

Candidates must be examined by a doctor and certified:-

- a) Not to have any medical conditions that will adversely impact their ability to carry out his/her job scope and
- b) Fit for employment based on the physical examination, chest x-ray and the doctor's assessment.

**IV. STAFF'S PARTICULARS**

Name (as in NRIC/UIN): \_\_\_\_\_ NRIC No. /UIN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Expected Start

Date of Employment: \_\_\_\_\_ Contact No: \_\_\_\_\_

Centre's Name (State Branch): \_\_\_\_\_

Centre's Address: \_\_\_\_\_

\_\_\_\_\_

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**V. MEDICAL HISTORY (TO BE COMPLETED BY THE SCC STAFF)**

(Have you **EVER SUFFERED FROM OR BEEN TREATED** for any of the conditions below? Please tick the appropriate box. If 'Yes', please include details

	Yes	No	Details
1. Psychiatric disorders or nervous breakdown (includes anxiety and depression)			
2. Epilepsy			
3. Tuberculosis			
4. Others (to specify): <hr/>  			

**DECLARATION:**

I declare that all the information provided in this form are true and correct, and that I have not withheld any information of medical concerns of a similar nature, that will affect my ability to carry out my job at the Student Care Centre.

\_\_\_\_\_  
Name and Signature of SCC staff

\_\_\_\_\_  
Date

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**VI. CERTIFICATION BY EXAMINING DOCTOR**

I certify that I have examined \_\_\_\_\_ (Name and NRIC/UIN) and assessed him/her \* **FIT / UNFIT** for employment in the Student Care Centre, based on his/her mental and physical health and public health risk.

**Name of Doctor:** \_\_\_\_\_

**Name and Address of Clinic:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Tel No.:** \_\_\_\_\_

Stamp of Clinic:

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\* Delete accordingly