(To be filled in by Pusat Sejahtera)
Receipt No.:

To: **Payment Counter**
Bursary Department

From: **Clinical Unit**
Pusat Sejahtera

Name: ____________________

New Passport No.: ____________________ Old Passport No.: ____________________

USM ID: ____________________ Malaysian Phone No.: ____________________

Please tick ☑ which applicable		**Amount Charge (RM)**
Medical Check Up (Package [P])	☑	
Medical Check Up (Single [S]) ☐ Consultation ☐ Chest X-ray ☐ HIV ☐ HCV ☐ Hbs Ag ☐ VDRL ☐ BFMP ☐ UFEME ☐ U/Amphetamine ☐ U/Morphine & Cannabis OTHER	☐	
No. Akaun: 401.CKESIU.550001 **Total amount to be paid to Payment Counter:**		**360.00**

Date:

Signature & Chop
Staff-in-Charge Medical Check Up
Pusat Sejahtera

Date:

Signature & Chop
Payment Counter, Bursary Department

MEDICAL EXAMINATION CHECKLIST

DATE:

NO.	PROCEDURES	REMARKS
1	COVID SCREENING	
2	REGISTRATION	
3	DOCUMENT PREPARATION	
4	PAYMENT	
5	URINE & BLOOD SAMPLING	
6	PHYSICAL EXAMINATION	
7	X-RAY	
8	REPEAT URINE (IF NECESSARY)	
9	REGISTRATION (QUE NUMBER)	
10	DR CONSULTATION	
11	SUBMISSION	

Please tick ( ) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illness.

- Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illness					

I also hereby confirm the following:

i. I have not take/taken (if taken, please specify) any medication/drugs within the last two weeks; and

ii. My last menstrual period was on _____/_____/_____ (DD/MM/YY) (FEMALES ONLY)

____

Student Signature

For Staff Only

Wt :

Ht :

BP :

PR :

Eye Test **Rt :** **Lt :**

(Aided / Unaided)

Colour Vision : Normal / Abnormal

X-RAY NO :