



MALAYSIAN TECHNICAL COOPERATION PROGRAMME SCHOLARSHIP

MEDICAL REPORT (to be completed by an authorized physician)

Name of Applicant:			
Age:	Gender:	Height: cm	Weight: kg
Blood Pressure:			
Blood Group: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O <input type="checkbox"/> Other ()			
Any history of surgery?		Is the person examined physically and mentally able to carry out intensive training away from home?	
Is the person free of infectious diseases (AIDS, tuberculosis, trachoma, skin diseases, Covid-19, etc.)?		Does the person examined have any condition or defect (including teeth) which might require treatment during the course?	
List any abnormalities indicated in the chest X-ray:		Pregnancy Test:	
I certify that the applicant is medically fit to undertake a course in Malaysia.			
Name of Physician	:	_____	
Address of Clinic	:	_____ _____	
Telephone	:	_____	
Email	:	_____	
Date	:	_____	
Signature of Physician	:	_____	
Seal of Clinic	:	_____	