MEDICAL EXAMINATION REPORT
ᐋᓐᓂᐊᓯᐅᖅᑕᐅᔪᑏᑦ ᐊᓪᓚᑕᐅᓯᒪᔪᑎᖏᑦ/

THIS FORM HAS TO BE FILLED IN BY THE PHYSICIAN
ᑖᓐᓇ ᑕᑕᖅᓴᑕᐅᒥᐊᓕᒃ ᐋᓐᓂᐊᓯᐅᖅᑎᒪᓇᒻᒧᑦ

Patient's name / ᐋᓐᓂᐊᓯᐅᖅᑕᐅᔫᑉ ᐊᑎᖓ

Date of birth/ ᐃᓅᓕᖅᐱᖓᑕ ᐅᓪᓗᖓ

1. Is the patient in good physical and mental health?
ᐋᓐᓂᐊᓯᐅᖅᑕᐅᔫᖅ ᖃᓄᐃᖕᖏᓪᓚᖅ ᑎᒥᖓ ᐃᓱᒪᖓᓗ ?

Yes / ᐋ ☐ No / ᐊᐅᑲ ☐

Comments/ᐅᖅᑲᐅᓯᑦᓴᑎ:

2. Is the patient suffering from an illness or disability that makes him unable to work in a remote location?
ᐋᓐᓂᐊᖅᑳᖅ ᐅᕝᕙ ᓘᓐᓃᑦ ᐱᐅᓯᖅᓘᑎᖅᑳᖅ ᓄᓇᒥ ᖃᓂᖖᒋᑐᒥ ᐱᓇᓱᖖᒋᓪᓚᖅᑭᐅᑎᒋᒍᓐᓇᑕᖅᒥᓂᒃ ?

Yes / ᐋ ☐ No / ᐊᐅᑲ ☐

Comments/ ᐅᖅᑲᐅᓯᑦᓴᑎ:

Date of the medical examination
ᐅᓪᓗᖓ ᐋᓐᓂᐊᓯᐅᖅᑕᓂᕿᓂᖓᑕ

3. Has active tuberculosis been detected?
ᐳᕙᓪᓗᓇᖅᑲᓕᖅᑳ ?

Yes i / ᐋ ☐ No / ᐊᐅᑲ ☐

Date of tuberculosis test
ᐳᕙᓪᓗᒪᖔᑦ ᑲᒪᒋᔭᐅᔪᕕᓂᖅ ᐅᓪᓗᒥ ᐅᕙᓂ:

I certify that the information given is accurate and true/ ᑕᒃᑯᓂ ᐊᓪᓚᓯᒪᔪᓂᒃ ᓱᓕᓂᕈᔪᖓ ᓇᒻᒪᒃᓵᖅᓯᒪᑦᓯᑎᒃ

Physician's name in block letters
ᐊᑎᓕᐅᖅᐱᖓ ᐋᓐᓂᐊᓯᐅᖅᑎᒪᓇᐅᑉ ᐊᑎᖓ

Physician's signature
ᐋᓐᓂᐊᓯᐅᖅᑎᒪᓇᐅᑉ

Name of clinic and telephone number
ᐋᓐᓂᐊᕕᐅᑉ ᐊᑎᖓ ᐅᖄᓚᐅᑎᖓᓗ

Please attach your business card (your own or the clinic's) as proof that the examination took place.

Thank you for your cooperation

ᐱᓇᓱᕝᕕᐱᑦ ᐊᓪᓚᓯᒪᔪᖅᑯᑎᖓᓂ ᐊᑕᖅᑲᑕᐅᑎᑦᓯᓗᑎᑦ ᐋᓐᓂᐊᕕᐅᓪᓗᓃᑦ
ᐊᓪᓚᓯᒪᔪᖅᑯᑎᖓᓂᒃ ᖃᐅᔨᒪᒍᑎᐅᓛᖅᒪᑦ ᐋᓐᓂᐊᕕᓕᐊᖅᑐᕕᓂᐅᕆᐊᖓᓂᒃ.
ᓇᑯᖅᒦᒃ ᐃᑲᔪᕿᓐᓇᖅᐱᑦ.

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