



## JABATAN LAUT MALAYSIA

Ibu Pejabat Laut Semenanjung Malaysia, Peti Surat 12, 42007 Pelabuhan Klang  
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## LAPORAN PENGAMAL PERUBATAN

### MEDICAL PRACTITIONER'S REPORT

Saya telah memeriksa \_\_\_\_\_ No. KP/Pasport: \_\_\_\_\_

*I have examined*

*IC/Passport No:*

mengikut standard perubatan Jabatan Laut Malaysia JL/P/02/98 dan keputusannya adalah berikut:

*as per the Malaysian Marine Department medical standards JL/P/02/98 and the results are as follows:*

Tinggi/Berat \_\_\_\_\_ metres \_\_\_\_\_ kg  
*Height/Weight*

Pendengaran \_\_\_\_\_  
*Hearing* kanan *right* kiri *left*

Penglihatan \_\_\_\_\_  
*Eyesight* kanan *right* kiri *left*

Penglihatan dgn kacamata \_\_\_\_\_  
*Eyesight with visual aids* kanan *right* kiri *left*

Penglihatan Warna \_\_\_\_\_  
*Colour Vision*

Ujian Kencing *Urinalysis* \_\_\_\_\_ gula *sugar* \_\_\_\_\_ albumin

Nadi *Pulse* \_\_\_\_\_ /min

Tekanan darah \_\_\_\_\_  
*Blood pressure*

Chest X-ray Normal/Abnormal X-ray Number: \_\_\_\_\_

ECG Normal/Abnormal

KEPUTUSAN PEPERIKSAAN EXAMINATION RESULTS	
<b>LAYAK FIT</b>	<input type="checkbox"/>
<b>TIDAK LAYAK UNFIT</b>	<input type="checkbox"/>
<b>TIDAK LAYAK SEMENTARA TEMPORARILY UNFIT</b>	<input type="checkbox"/>

	Normal	Abnormal	Remarks
1 Infectious diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
2 Malignant Neoplasm	<input type="checkbox"/>	<input type="checkbox"/>	_____
3 Endocrine and Metabolic Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
4 Disease of the blood and blood forming organs	<input type="checkbox"/>	<input type="checkbox"/>	_____
5 Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
6 Central Nervous system	<input type="checkbox"/>	<input type="checkbox"/>	_____
7 Cardiovascular system	<input type="checkbox"/>	<input type="checkbox"/>	_____
8 Respiratory system	<input type="checkbox"/>	<input type="checkbox"/>	_____
9 Digestive system	<input type="checkbox"/>	<input type="checkbox"/>	_____
10 Genito-Urinary System	<input type="checkbox"/>	<input type="checkbox"/>	_____
11 Pregnancy	No	Yes	( week _____ ) _____
12 Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
13 Musculo-skeletal system	<input type="checkbox"/>	<input type="checkbox"/>	_____
14 Speech Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
15 Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
16 Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

Perakuan ini sah sehingga \_\_\_\_\_

*This certificate is valid until*

Tarikh

*Date*

Signature of Medical Practitioner  
MMC No: