

OCCUPATIONAL HEALTH AND SAFETY: GUIDELINES FOR HEALTH PROFESSIONALS



Occupational Health and Safety Program
Department of Public Health
Ministry of Health
Thimphu Bhutan



FOREWORD

With the unprecedented developmental activities taking place in the country, there will be increasing case load of occupation related injuries, diseases, disabilities and deaths for which health professionals will have to deal with and certify accordingly. Further, in order to keep pace with increasing awareness of the people's rights and privileges vis-a-vis the applicable statutes, the health professionals must be geared towards meeting these aspirations and medico-legal responsibilities.

However, the Occupational Health and Safety Program is still at a nascent stage in the country. As of now, there is no policy directive, guideline or standard to guide health professionals in dealing with Occupational Health and Safety (OHS) issues.

This guideline is developed in line with Labour and Employment act of Bhutan 2007. This guideline is intended to streamline medical certification processes pertaining to medical screening for employment, immigration and disability compensation purposes. In absence of the policy guideline we have come up with this guideline which will be a useful tool in management and certification of occupation related issues.

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PART A: GENERAL INFORMATION

Chapter 1: Purpose of This Guideline

This document is intended as a guide for all medical and health professionals who are engaged in occupational health and safety related activities including medical screening for employment purposes.

This guideline sets out standards and procedures for:

1. Pre-employment medical screening for general purposes
2. Assessment of fitness to drive motor vehicles
3. Assessment and certification of disability for compensation purposes.
4. Periodic medical examination for industrial workforce
5. Pre-employment screening for food handlers
6. Medical screening for visa application

In the course of the examination, the medical and health professional should look not only for physical disabilities but should also endeavour to assess the patient's mental and emotional state of mind to assess overall fitness for the particular job that he/she is applying for including driving. Either a single major impairment or multiple minor defects may make it unsafe or unfit for the job.

The guideline also provides a list of notifiable occupational diseases, conditions or ill health. If a health professional comes to discover a notifiable disease or condition in a person who is undergoing medical examinations for pre-employment screening and/or during periodic medical examinations of workmen, then the health professional must notify the concerned authorities without fail.

Chapter 2: Legal Requirements

The legal framework for this guideline is based on:

- Labour and Employment Act of Bhutan (LEAB) 2007, which is the primary legal framework for occupational health and safety. Chapter IX and chapter VI of LEAB contains legal provisions for Occupational Health and Safety, and Compensation and Benefits respectively;
- Workers' Compensation Regulations 2009, which sets out standards and procedures for compensation for employees and their dependants as a result of injury, diseases or death arising from their work or related to the tasks and duties they are required to perform;
- Bhutan Civil Service Rules and Regulations 2010, which requires medical fitness certification for recruitment, contract employment, civil service examination, medical leave and resumption of duties after availing medical leave, death and disability, compensation and resignation on medical grounds.
- Road Safety and Transport Act 1999, which requires medical fitness certification to apply for driving licence;
- Food Rules and Regulation of Bhutan 2007, Section 34.2: "Need for licence", and appendix I, section 2: "Agreement of Food handlers".
- National Pension and Provident Fund Regulations 2004, which requires medical certification for the purposes of compensation in lieu of injuries, disabilities and deaths of its members.

- Immigration Act of the Kingdom of Bhutan 2007, which provides scope for denial of Bhutanese visa to foreign applicants on medical grounds;
- Mineral and Mines Management Regulations 2002, which outlines occupational health and safety procedures to be followed in the mining industries;
- Bhutan Electricity Authority Safety Regulations 2008, which prescribes safety procedures to be followed in design, construction, operation and maintenance of electric power plant and equipment in a manner that is electrically safe;
- Rules and Regulations for Establishment and Operation of Industrial and Commercial Ventures in Bhutan 1995, which requires the business licensees to follow the standards laid down in respect of health and hygiene and environmental protection;
- Bhutan Building Rules 2002, which makes reference to aspects of safety on construction sites;
- Medical and Health Council Act 2002 that stipulates that only medical or health professionals who are registered with the Bhutan Medical and Health Council will issue certificates and/or medical reports.

Legislation provides legal indemnity to health practitioners who conduct medical examination and provide patient's medical information to the appropriate authority.

However, the health practitioner may be liable for legal actions if the court forms an opinion that the practitioner has wilfully or negligently certified impaired candidates thereby placing such candidate or the general public at risk.

Chapter 3: Role of Medical or Health Professionals

A medical or health professional shall have to:

- Integrate occupational history in routine history taking;
- Treat persons with occupation related health problems;
- Refer persons with occupational injury/ disease to appropriate specialist when necessary;
- Assess the degree of impairment and working ability following occupation related accidents or diseases;
- Perform jobs specific and general pre-employment medical screening and examinations and certifications;
- Perform periodic and other health assessments;
- Conduct epidemiological investigation into outbreaks of ill health conditions related to occupation or workplace;
- Advise employees and employers on protective measures against occupational health hazards;
- Notify the concerned authorities on notifiable occupation-related diseases and chemical hazards;

Chapter 4: Ethical Issues

As per the International Commission on Occupational Health, “determination of fitness for a given job should be based on the assessment of the health of the worker and on a good knowledge of the job demands and of the work site”.

The occupational health practitioner has to explain necessity of public health policy, ergonomic arrangement, training for the job requirement, and medical supervision, in order to attenuate, as much as possible, discriminations based on age, gender, illness or handicap, and try to maintain equal opportunity for all.

Occupational health professional must serve the health and social wellbeing of the workers, individually and collectively.

Within the limits of the professional duty to maintain the confidentiality, the health professionals must communicate to the applicant and the potential employer whether or not the applicant is fit for the applied job. In the event of the applicant harbouring any notifiable or communicable diseases or conditions, then appropriate authority must be notified.

For example, if, in the case of a driver, a doctor is of the opinion that the driver has a medical condition that might seriously interfere with the person’s ability to drive safely then the doctor must use all his influence to urge the driver to refrain from driving if the condition is temporary until the condition is adequately treated, or to surrender the driving license if the condition is likely to be permanent. If the driver continues to drive even after repeated cautioning, the doctor should notify the concerned authorities about the person’s condition.

For compensation claims for work related injuries, diseases, disabilities or deaths, the health professional must assess any contributory factors that may have resulted and/or aggravated the injuries, diseases, disabilities or deaths. If the health professional is satisfied that the patient habits, such as ingestion of alcohol or drugs, non-compliance with safety measures and standards, have contributed to the injuries, diseases, disabilities or deaths, these must be reflected in the report.

On the other hand, if during the course of medical investigation the health professional discovers that the employer has not provided the prescribed safety standards, then the appropriate enforcement authorities must be notified.

PART B: MEDICAL SCREENING PROTOCOLS

General considerations:

For The Applicants:

All applicants must:

1. Produce relevant medical screening forms which are duly filled in as per the requirements. The medical screening forms will also be made available online.
2. Produce documentary evidence to prove their identity, such as citizenship identity cards, work permits, passports or voter cards.
3. Bring a recent passport size photograph, which is to be attached to the medical screening form wherever applicable.
4. Produce evidence of payment of fees for medical screening, wherever applicable.
5. Present in person for medical screening procedures;

For Medical and Health Professionals:

The medical or health professionals:

1. Must receive a request (in writing, where applicable, example a medico-legal case) from the applicant and/or the employing agency/court/insurance agency/enforcement authorities/police and other authorities for medical examination and certification citing the reason or purpose for which it is to be used.
2. Conduct consultation- interview, examination, laboratory investigations, reference to medical documents (e.g., birth registration, patient case sheets) and consultations with relevant specialist where required.
3. Document the findings using appropriate medical screening forms (A to E).
4. Assess whether or not the applicant is fit for certification.
5. Return the completed screening forms and retain a copy for future reference.
6. Complete medical certificate or report, if one is to be issued.
7. Store the documents in an appropriate manner.

Medical Certificate and/or Report:

A medical certificate or report must:

1. Be legible;
2. Be written in the designated format or forms designed specifically for the purposes covered under this guideline.
3. Be written in plain English, avoiding use of technical or medical jargon wherever possible.
4. Be based on facts known to the practitioners and based on their own observations made during examination and investigations.
5. Contain date of consultation and date of certification.
6. Contain the name, age, sex and the address of the person examined.
7. Specify the purpose for which the certification was issued.
8. Be completed by a registered medical or health practitioner who is authorised to do so.
9. Contain the name, designation, BMHC registration number and the official seal.
10. Not be backdated or predated.
11. Be issued only once. But in the event of the certificate/report being lost or misplaced and if a request for duplicate copy is made, the photocopy of the original certificate maintained by the health facility may be issued by the practitioner who had issued the original certificate/report or in his absence by another practitioner who is authorised to do so. Such document must be clearly marked as “DUPLICATE” and attested.
12. Be stored properly for adequate time period which may be prescribed by policies or regulations developed for the purpose from time to time.

Chapter 5: Medical Screening for General Purpose

This section deals with medical certification for general purposes, such as general employment and for in-country training (other than driving, food handling, mining and industries) and expatriate workforce other than those engaged in construction industries.

For this purpose, *Form A* must be used to document personal information, physical examination findings, and laboratory investigations and other tests reports.

Part I and part II relates to personal information and medical history respectively. These parts must be filled by the applicant and declared.

Part III relates to general and systemic examination. This part must be completed by the examining practitioner for all the applicants.

For electricians, security guards and such other occupations (*which require prolonged standing, climbing heights, lifting heavy weights etc.*), part IV must be completed in addition to part III.

For each of the variable under part III and/or part IV, document the findings and indicate whether these are normal or abnormal. If the findings are abnormal, give a brief explanatory note against each finding.

In Part V, the medical and health professional must certify and declare whether or not the applicant is fit based on his professional judgement arrived after considering the observations from the medical examinations, and findings from other tests.

The certifying practitioner must consider the demands of the job the applicant is applying for when assessing the person's fitness for the job. The mere presence of a treatable illness or a condition is not a disqualification for the job; however the condition or the illness should not be of a serious public health concern.

If applicant has any illness or condition that is of concern to the applicant and/or the general public, he/she may be issued a conditional certification of fitness, wherein the applicant must undergo prescribed medical treatment until the illness or condition ceases to be hazardous to the applicant and the general public.

This certificate is valid for a period of six months from the date of issue.

Chapter 6: Medical Screening to Assess Fitness to Drive Motor Vehicles

This section deals with medical assessment for fitness to drive motor vehicles.

For this purpose, *Form B* must be used to document personal information, medical history, physical examination and investigations.

Part I and part II must be filled by the applicants.

Part III relates to general and systemic examination. This part must be completed by the examining practitioner for all the applicants.

For each of the variable under part III, document the findings, and indicate whether these are normal or abnormal. If the findings are abnormal, give a brief explanatory note against each finding.

In Part IV, the medical and health professional must certify and declare whether or not the applicant is fit based on his professional judgement arrived after considering the observations from the medical examinations, and findings from other tests.

Person shall be certified UNFIT for driving if the person has:

1. Best corrected vision in both eyes worse than 6/9
2. Best corrected vision worse than 6/12 and better than 6/60 (conditional driving license)
3. Colour blindness
4. Visual field less than 120 horizontal and 20 vertical
5. Deafness(Severe)(Professional driving purpose)
6. Uncontrolled epilepsy (more than 3 episodes of seizures in the last 3years)
7. Uncontrolled diabetes mellitus
8. Recurrent or disabling vertigo
9. Untreated Major Mental disorders (severe depression, psychosis, manic episode in bipolar disorder, severe anxiety, attention deficit hyperactivity disorder, etc.)
10. Age below 18 year (and below 17 years in the case of learner's licence).

A higher level of fitness is required of professional drivers who operate passenger carrying vehicles, trucks and emergency vehicles. These drivers spend many more hours at the wheel often under far more adverse driving conditions than do the drivers of private vehicles.

Persons operating emergency vehicles are frequently required to drive while under considerable stress by the nature of their work, and often in inclement weather where driving conditions are less than ideal. This group, too, should be expected to meet higher medical standards than private drivers.

Professional drivers including those operating emergency vehicles (fire, ambulances, etc.) should be made to undergo medical screening every three years or as and when required by enforcement authority.

Elderly drivers who do not exhibit any medical contraindication to driving but who show the early manifestations of a number of chronic conditions such as failing eyesight, degenerative joint disorders, slowed responses or a tendency to become confused in fast or heavy traffic may still be able to drive safely if they are restricted to familiar local streets or to driving only during daylight hours, perhaps at a reduced speed.

Conditional licenses should be recommended whenever it is felt essential that a patient remain under close medical observation because of a chronic progressive disability or a medical condition that is prone to sudden and unpredictable relapses.

If, after completing a driver's medical examination, a physician is undecided about a patient's fitness to drive, consultation with an appropriate specialist should be considered.

Although the physician is asked to evaluate a patient's medical fitness to drive safely, the person's actual ability to drive may be determined by the licensing authority through a driving test and the decision to issue or refuse a license is made by the concerned authority. A physician who is uncertain about the fitness of an elderly patient or someone with a significant physical or mental handicap should never hesitate to recommend a practical road test as another avenue for assessing fitness to drive.

This guideline will not apply to air pilots and cabin crew employees as their medical screening and examinations will be conducted by a panel of aviation medical professionals

as may be appointed by the aviation industry from time to time in consultation with health authorities.

Chapter 7: Medical Screening for Food Handlers

This section deals with medical certification for food handlers who are seeking employment in hotels, catering services, restaurants, food and beverages industries, or as cooks in institutions.

For this purpose, *Form C* must be used to document personal information, physical examination findings, and laboratory investigations and other tests reports.

Part I and part II relates to personal information and medical history respectively. These parts must be filled by the applicant and declared.

Part III relates to general and systemic examination. This part must be completed by the examining practitioner for all the applicants.

For each of the variable under part III, document the findings and indicate whether these are normal or abnormal. If the findings are abnormal, give a brief explanatory note against each finding.

The health professional must screen for presence of:

- food borne diseases, such as:
 - hepatitis A and C
 - typhoid
 - cholera
 - common protozoal infections in human
 - helminthiasis

- Communicable diseases:
 - Tuberculosis (sputum positive)
 - Influenza
 - Skin infections like scabies, pediculosis, fungal infections etc.
 - Discharge from eyes, ears and nose.

- Systemic conditions:
 - Seizure disorders
 - Diabetes
 - Hypertension
 - Vertigo
 - Major psychiatric disorders
 - Drug and alcohol addiction

In Part IV, the medical and health professional must certify and declare whether or not the applicant is fit based on his professional judgement arrived after considering the observations from the medical examinations, and findings from other tests.

If applicant has any illness or condition listed above, the applicant must be certified temporarily unfit to be employed in food handling industries/business outlets. They must

produce documentary evidence of having undergone standard medical treatment prior to being certified fit for food handling purpose.

This screening protocol must be followed both for fresh applicants and to those who come for renewal /extension of their employment tenure/contract.

Chapter 8: Medical Screening for Expatriate Workforce

This section deals with medical screening for expatriate workforce (non-immigrant workers) recruited from other countries to work in various construction industries in Bhutan.

For this purpose, *Form D* must be used to document personal information, physical examination findings, and laboratory investigations and other tests, if deemed necessary.

Part I of the form relates to personal details and the employer's information and this must be completed by the applicant, who must affix signature/thumb impression across a recent passport size photograph.

Part II pertains to personal medical history where the applicant must declare with assistance from medical or health professional whether or not he/she has the condition(s) listed in the form.

Part III of the form deals with physical examination and this must be conducted by an authorized medical or health professional. He/she must conduct detailed examination as listed in the form providing details of abnormalities, if detected. In particular, he/she must screen for conditions that might interfere with the person's optimal performance and for any conditions that might have public health implications.

The health professional may carryout additional investigations which are not reflected in the form, if deemed necessary as adjudged from his medical evaluation of the applicant. Further he may seek advice or consultation from relevant specialities.

Part IV of the form deals with the mandatory investigations, which must be carried out in authorized health/diagnostic centres in Bhutan. The date of investigations and name of the centres where such tests were carried out must be mentioned. The original X-ray and laboratory reports must be attached for verification by the examining medical or health professional.

Part V deals with certification of the applicant. The medical or health professional must declare and certify whether or not the applicant is fit/unfit based on his professional judgement arrived after considering the observations from the medical examinations, and findings from other tests.

The mere presence of a medical illness or a condition is not necessarily a disqualification for the job. However, the condition or the illness should not be of a serious public health concern. If applicant has any illness or condition that is of concern to the applicant and/or the general public, then such person should be declared unfit but the applicant must be advised to undergo prescribed medical treatment until the illness or condition ceases to be hazard to the applicant and the general public after which the applicant may reapply.

Where the practitioner is of the opinion that the applicant is fit for the proposed job but with certain restriction, the practitioner must specify such restriction, e.g., limited number of working hours, restricted prolonged sitting or squatting, lifting of weights, climbing heights etc.

The medical certificate is valid for a period of two years from the date of issue. However, if he/she is absent from Bhutan for 30 days or more, then he/she is required to undergo re-entry medical screening as deemed necessary by the immigration office.

This screening protocol must be followed for:

- (i) Fresh applicants;
- (ii) Workmen who wish to apply for renewal /extension of their employment tenure/contract; and
- (iii) Worker with a valid medical fitness certificate who opts to change the profession or apply for work in areas or settings that are different from those against which earlier certification have been issued.
- (iv) Re-entry medical screening if absent from Bhutan for more than 30 days.

Chapter 9: Medical Screening for Industrial Workforce

This section deals with medical screening for industrial workforce. In addition to this form, those applicants who apply for employment in food and agro-based industries must also undergo screening using *form C*.

For this purpose, *Form E* must be used to document personal information, physical examination findings, and laboratory investigations and other tests reports.

Section A must be completed by the applicant, who must affix a passport size photograph on the form.

Part I of section A relates personal details and the employer's information.

Part II pertains to personal medical history where the applicant must check whether or not he/she has the condition(s) listed. If they declare a condition(s) details about the condition(s) must be provided.

Part III relates to the applicant's declaration of specific medical condition(s) and habits such as smoking, drinking alcohol or substance abuse, difficulties related to certain postures and lifting weights, climbing heights, etc.

In section B, the medical and health professional must conduct detail examination as listed in the form providing details where abnormalities were detected. In particular, he must screen for conditions that might interfere with the person's optimal performance. He must also screen for any conditions that might have public health implication to Bhutan.

The health professional may carryout additional investigations which are not reflected in the form if deemed necessary as adjudged from his medical evaluation of the applicant. Further he may seek advice or consultation from relevant specialities. All the findings must be properly documented for future reference.

In section C the health professional must declare and certify whether or not the applicant is fit based on his professional judgement arrived after considering the observations from the medical examinations, and findings from other tests.

The mere presence of a medical illness or a condition is not necessarily a disqualification for the job; however the condition or the illness should not be of a serious public health concern.

The health professional should instruct the applicant to notify the employer and the health authority of any illnesses, including allergic reactions to various chemicals, dusts and other agents that the applicant may develop during the course of his employment.

If applicant has any illness or condition that is of concern to the applicant and/or the general public, he may be issued a conditional certification of fitness, wherein the applicant must undergo prescribed medical treatment until the illness or condition ceases to be hazard to the applicant and the general public.

Where the practitioner is of the opinion that the applicant is fit for the proposed job but with certain restriction, the practitioner must specify such restriction, e.g., limited number of working hours, restricted prolonged sitting or squatting, lifting of weights, climbing heights etc.

These forms must be filed in the workers personal dossiers and stored in a secure place indefinitely.

PART C: DISABILITY ASSESSMENT PROTOCOL

Chapter 10: Assessment of Disability

The medical or health professional may have to undertake medical examination to facilitate a workman or his surviving family member(s) to claim compensation for injuries, illnesses, disabilities or death arising within the scope of the person's employment.

The disability certificate may be issued only on the production of requisition letter from the court, employing agency, insurance, National Pension and Provident Fund, police or other enforcement agencies.

For this purpose *Form F* must be used for screening and certification must be done using the "Disability Certificate".

For this, the health professional must undertake detailed evaluation of the person's illness or injuries including all the relevant investigations and tests, and specialists' consultation, in order to answer questions to the following:

1. Is the illness/injury due to occupation?
2. What is the effect of occupation on the illness?
3. What is the effect of illness on the occupation?

The health professional must have high index of suspicion for occupational diseases because of the difficulties posed by long latency period, exacerbation of pre-existing diseases, genetic susceptibility and personal habits.

Useful pointers to occupational aetiology are:

- Association of symptoms with specific work;
- Improvement of symptoms when away from work during weekends or vacations;
- History of direct exposure to dusts, fumes, and chemicals;
- Other workers are also affected.

The health professional must also assess the nature of disability as defined in the Workmen Compensation Regulation 2009, as follows:

1. **"Disability"** means inability to perform a range of tasks to reasonable standard considered normal for a particular job or work activity due to some physical, mental, or sensory impairment. The degrees of disability are assessed in relation to a job or work activity rather than the extent of physical, mental or sensory impairment.

Disability can be either partial or total, both of which can be temporary or permanent.

2. **"Temporary partial disability"** means a condition where an injured employee's capacity is impaired for a time, but he/she is able to continue working at reduced efficient or temporarily cannot perform his/her normal task but expected to fully recover.
3. **"Temporary total disability"** means a condition where an injured employee's capacity to work is totally disabled for a temporary period.

4. **“Partial Permanent disability”** means a condition where an injured employee’s capacity to work is partially disabled for lifelong.
5. **“Total permanent disability”** means that because of injury due to work accident or occupational diseases, an employee is unable to work in his/her occupation for which he/she is suited by training, education or experiences and will be unable to perform any task through his/her lifetime or he/she will not recover or that in all possibility will continue indefinitely, e.g., loss of both eyes, arms or legs.

The health professional must use the Disability Chart to assess the degree of disability.

Fitness for work:

After having made the assessment of disability, the health professional must also determine the level of fitness of the workman to discharge his entrusted job or responsibility with his current injury or illness.

- If the workman is fit to return to his pre-injury duties with no further treatment required, the health professional must certify accordingly.
- If the workman is fit to return to his pre-injury duties but requires further treatment, then the nature and the duration of further treatment must be specified.
- If the workman is fit to return to his pre-injury duties but for restricted hours or days of work, this must be clearly specified, e.g., 3 hours for 2 days per week.
- If the workman is fit to return to his pre-injury duties but requires certain restrictions, such restrictions must be specified e.g., *Avoid prolonged standing/walking/sitting; Avoid squatting/ kneeling/ ladders/ steps, etc.*
- If the workman is completely unfit for temporary period, then the duration and the reason for which the workman is unfit should be specified, e.g., following surgery requiring hospitalization.
- If the workman is totally unfit for his pre-injury duties, then the nature of injury must be clearly specified and recommendation for a suitable alternative job may be provided.

Medical Board of Doctors:

The disability certification must be endorsed by a three member board of medical doctors, including the treating practitioner.

The medical board shall be constituted on an ad hoc basis by the hospital authority, who must ensure that the members have no conflict of interest. Where medical professionals with the requisite expertise are not available, the case may be referred to an institution or hospital where such expertise exists.

All the members must be present at the time of objective assessment and subsequent endorsement.

The members shall base their endorsement on objective assessment of the person’s overall condition.

The board members may be remunerated in accordance with applicable laws and policies.

Chapter 11: Disability Assessment Chart


Body part / System	Nature of Disability			
	Temporary Partial	Temporary Total	Permanent Partial	Permanent Total
Brain & Nervous System	Superficial injuries to the scalp	Concussion	Any of the cranial nerve lesions	Injuries or conditions resulting in permanent and incurable paralysis
Cervical Spine	Superficial injuries	Disc prolapse, compression fractures, infections (TB, pyogenic, & viral)	Cervical spondylosis, myelopathy, (tumour, traumatic, degenerative)	tetraplegia
Thoracic spine	Superficial injuries	Disc prolapse, compression fractures, infections (TB, pyogenic, & viral)	Compressive myelopathy, (tumour, traumatic, degenerative), Paraparesis	Paraplegia
Lumbar spine	Superficial injuries	Disc prolapse, compression fractures (TB, pyogenic, & viral)	Compressive myelopathy, (tumour, traumatic, degenerative), Caudaequina syndrome, paraparesis	Foot drop, Caudaequina syndrome
Sacral spine	Superficial injuries	Coccydynia	Tumours	
Eyes	Example: Conjunctivitis, stye, dacryocystitis, foreign body, ocular injury	Iritis, uveitis, chemical burns without loss of sight, glaucoma, Cataract (acquired), pterygium	Total loss of sight in one eye	Total loss of sight in both eyes
Ears	foreign body in the ears, injury to pinna	Vertigo, Meniere's disease, any ear conditions necessitating surgery,	Total loss of hearing in one ear	Total loss of hearing in both ears
Speech	Psychogenic aphonia,	Tracheitis, laryngitis, foreign body or growth in the larynx	Chronic infection, Tumour of larynx etc. causing difficulty in speaking	Total loss of speech
Sense of taste				Total loss of sense of taste
Nose/smell	Running nose, allergy, sinusitis			Total loss of sense of smell
Hands	Cut, bruises, cellulitis etc.	Uncomplicated fractures of humerus	Loss of one hand at wrist;	Loss of both hands
		Uncomplicated fractures of radius or ulna, ligamental tears	Loss of arm at or below elbow;	
		Uncomplicated fractures of	Loss of any single or combination of	

		metacarpals, carpals and phalanges	fingers;	
Legs	Cut, bruises, cellulitis etc	Fracture of the pelvis, neck of femur, shaft of femur and supra-condylar fractures, patellar fracture, ligament tears.	Loss of one leg at or above knee	Loss of both legs at or above knees
		Fractures of tibia, fibula,	Loss of one foot	Loss of both feet
		Fractures of medial and lateral malleoli, tarsals, metatarsals and phalanges	Loss of single or combination of toes in one or both feet.	
Reproductive system			Partial loss of reproductive function	Total loss of reproductive function
Oro-dental	Mobile tooth	Fracture of tooth	Dislocation /loss of up to 5 teeth	Dislocation /loss of more than 5 teeth
Scarring	Superficial injuries from sharp/blunt force	Scalds up to 40% burns	Chemicals, scalds and flame burns up to 40 % body surface area	Chemicals, scalds and flame burns more than 40 % body surface area
Other body parts	Injury or disease to any member or part thereof not covered above	Injury or disease to any member or part thereof not covered above and necessitating medical procedures	Loss of any member or part thereof not covered above	-
Mental disorders	Mild to moderate depression, Anxiety disorders of mild to moderate degree (acute reaction to stress, adjustment disease),	Acute psychotic episode, Severe forms of depression or anxiety disorders, Bipolar affective disorder, uncontrolled panic disorder, uncontrolled seizure disorder, PTSD etc.	Chronic depression (dysthymia), rapid cycling bipolar affective disorder, Attention deficit hyperactivity disorder,	Schizophrenia, phobic anxiety disorder, dementia, organic brain syndrome etc.
Respiratory system	Upper and lower respiratory tract infection	Blunt or penetrating injuries to the thoracic cavity requiring medical or surgical interventions, chronic lung infections	Conditions requiring partial resection of the lungs, chronic obstructive lung diseases, bronchial asthma, etc.	Cancer, pneumoconiosis, asbestosis, interstitial lung diseases
Cardiovascular				
Skin	Eczema, urticaria, sunburn,			Skin cancer


PART D: Filling up Medical Certificate Forms

Chapter 12: How to fill Medical Certificate Form

Completed samples of screening form and certificate are shown below.



དཔལ་ལྷན་པ་རྒྱལ་ཁབ་ཀྱི་
 བཞུགས་སྐྱོང་ལྷན་ཁག་།
ROYAL GOVERNMENT OF BHUTAN
Ministry of Health



Reg. No. MC/JDWRH/123 **Medical Certificate**

I certify that I have examined

Full name KOTLE WRAGEI

Age/Sex 22Y/M bearing Citizenship ID /Passport /Voter card No. 1110000000 on (date) 04/09/2011 as a candidate applying for (Specify purpose) CA/LS/102 (Electrician)

In my opinion, the person examined is (check appropriate box):

1. In a state of good physical and mental health, and there is nothing to disqualify him/her on medical grounds for the purpose for which this certificate is issued.

2. Not fit for the specified purpose applied.


Additional comments:
Person is suffering from uncontrolled seizures and is put on medication now.

Signature of Certifier: [Signature]

Name: Dr. Damber K. Nirola

Designation: Specialist III Psychiatrist BMHC Reg. No.: MM-108

Date (certificate is signed): 04/09/2011 Dr. Damber K. Nirola
 Psychiatrist
 JDWRH
 BMHC Reg. No. MM-108



This certificate is valid for a period of six months from the date of issue.

Note: The examining doctor should carry out pre-employment medical screening as indicated below:
 For General purpose: form A; driving purposes: Form B; food handlers: Form C; expatriate workforce: Form D, industrial workforce: Form E.

Completed sample of disability certificate:



འབྲུག་རྒྱལ་ཁབ་འཕུལ་གཞི་རྒྱུ་གཞི
གསལ་བློན་པོ་ལྷན་ཁག་།

ROYAL GOVERNMENT OF BHUTAN
Ministry of Health



Reg No.....

DISABILITY CERTIFICATE

I certify that I have examined

Full name Karma Wangdi
 Age/Sex 43/M bearing Citizenship ID /Passport /Voter card No. 123009876 on
 (date) 17/09/2011 who is employed as Foreman in
Cement Factory, Pasakha (Agency)

In my opinion:

A. CAUSE OF INJURY / ILLNESS: (tick appropriate cage):

(a) Related to work ? (b) Not related to work ? (c) Of uncertain cause (comment):

B. NATURE OF DISABILITY* (tick appropriate cage):

(a) Temporary partial (b) Temporary total (c) Permanent partial (d) Permanent total

C. FITNESS FOR WORK (Tick those boxes which apply):

? (a) Fit to return to pre-injury duties, no further treatment required;

? (b) Fit to return to pre-injury duties, but requires further treatment;

? (c) Fit to return to work for restricted hours/days from _____ to _____

? (d) Fit to return to work on restricted duties from
 ? Avoid prolonged standing/walking/sitting
 ? Avoid squatting/kneeling/ladders/steps
 ? No lifting of heavy objects
 ? Avoid repetitive use of affected body part
 ? Avoid repetitive bending/lifting
 ? Other: _____

? (e) Unfit to work for 2 weeks

? (f) Unfit for present work

Signature of Certifying Practitioner: [Signature]
 Name: Dr. Tshawang Thinley Designation: Medical Officer
 BMHC Reg. No.: MM-112 Health Centre: District Hospital, Bajo
 Date (certificate is signed): 17/09/11 Official Seal: _____

Medical Endorsement
 After having discussed the patient's illness and medical interventions with the treating practitioner, we hereby endorse the opinion expressed by the certifying practitioner.

[Signature]
 Dr. Dorji, SMO, MM-90
 Signature of Treating Practitioner
 Name/Designation/BMHC Reg. No.

[Signature]
 Dr. Sonam Norden, Orthosurgeon, MM-54
 Signature of Medical Practitioner
 Name/Designation/BMHC Reg. No.

Note:

- The Medical assessment of disability relates to the physical impairment only. The employing agency or compensating agency must assess other aspects of disabilities such as social, vocational and psychological impairment.
- In order to complete the disability certification, the examining doctor should use Form F and Disability Assessment Chart.

PART E: APPENDICES

Form A: Medical Screening for General Purpose

Part I and II of this form to be completed by the applicant:

Part I: Personal Information

Name	Nationality	Passport No/Identity Card No./Voter Card No.
Date of Birth/Age	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Occupation
Residential Address in Bhutan:		
Contact Number:		

Part II: Medical History (To be declared and signed by the applicant)

	Yes	No	If yes, give brief details		Yes	No	If yes, give brief details
1. Mental illness				2. Epilepsy			
3. Asthma/COPD				4. Diabetes Mellitus			
5. Hypertension				6. Tuberculosis			
7. Heart Disease				8. Kidney Disease			
9. Addiction to drugs or alcohol				10. Prolonged or repeated hospital admission			
11. Major Surgical Operations/ Long-term medication				12. Physical deformity			
13. Visual problem				14. Hearing Impairment			

I declare that all the information given above is correct and true. I also understand that I may be liable for actions by the concerned authority for providing false or misleading information.

Signature of the applicant.....

Date.....

Part III: Physical Examination: (to be completed by a registered medical or health person only)

A. General	Normal	Abnormal	Brief details (if Abnormal)
1. Pulse rate..... Per min			
2. Blood pressure/..... mm Hg			
3. Conjunctiva (Circle) Pallor/non-icteric/others (specify)			

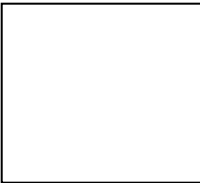
4.	Lymphadenopathy																					
5.	Pedal oedema																					
6.	Visible deformity																					
B. Systemic																						
7.	Nervous system (sensory and coordination)																					
8.	Cardiovascular system																					
9.	Respiratory system																					
10.	Per abdomen- General Liver Spleen																					
11.	Any other relevant system as may be required by the medical history																					
Part IV: For security guards, electricians, others (<i>specify</i>)																						
12.	Visual acuity <table style="margin-left: 40px;"> <thead> <tr> <th></th> <th>RE</th> <th>LE</th> </tr> </thead> <tbody> <tr> <td>Unaided</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Pinhole</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Corrected</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Near vision</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>Colour vision</td> <td colspan="2"><input type="text"/></td> </tr> </tbody> </table>		RE	LE	Unaided	<input type="text"/>	<input type="text"/>	Pinhole	<input type="text"/>	<input type="text"/>	Corrected	<input type="text"/>	<input type="text"/>	Near vision	<input type="text"/>	<input type="text"/>	Colour vision	<input type="text"/>				
	RE	LE																				
Unaided	<input type="text"/>	<input type="text"/>																				
Pinhole	<input type="text"/>	<input type="text"/>																				
Corrected	<input type="text"/>	<input type="text"/>																				
Near vision	<input type="text"/>	<input type="text"/>																				
Colour vision	<input type="text"/>																					
13.	Hernia, hydrocoele																					
14.	Stigmata for alcohol and drug abuse																					
Part V: Certification and declaration																						
Name and signature of the examining medical or health person		BMHC registration No. and Address:																				

Photo

Form B: Medical Screening for Driving Licensing

Part I and II of this form to be completed by the applicant:

Part I: Personal Information		
Name	Nationality	Passport No/Identity Card No./Voter Card No.
Date of Birth/Age	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Occupation
Residential Address in Bhutan:		
Contact Number:		

Part II: Medical History (To be declared and signed by the applicant)							
	Yes	No	If yes, give brief details		Yes	No	If yes, give brief details
1. Mental illness				2. Epilepsy			
3. Asthma/COPD				4. Diabetes Mellitus			
5. Hypertension				6. Vertigo			
7. Heart Disease				8. Addiction to drugs or alcohol			
9. Hearing Impairment				10. Visual problem			
11. Long-term medication				12. Physical deformity			
<p>I declare that all the information given above is correct and true. I also understand that I may be liable for actions by the concerned authority for providing false or misleading information.</p> <p>Signature/thumb impression of the applicant.....</p> <p>Date.....</p> <div style="text-align: right;">  Thumb Impression </div>							
<p>Note: The applicant should inform the licensing authority if he/she develops medical condition that might interfere with driving ability.</p>							

Part III: Physical Examination: (to be completed by a registered medical or health person only)

C. General		Normal	Abnormal	Brief details (if Abnormal)
1.	Pulse rate..... Per min			
2.	Blood pressure/..... mm Hg			
3.	Conjunctiva (<i>Circle</i>) Pallor/non-icteric/others (<i>specify</i>)			
4.	Lymphadenopathy			
5.	Pedal oedema			
6.	Visible deformity			
D. Systemic				
7.	Nervous system (sensory and coordination)			
8.	Cardiovascular system			
9.	Respiratory system			
10.	Per abdomen- General Liver Spleen			
11.	Stigmata for alcohol and drug abuse			
12.	Visual acuity RE LE Unaided <input type="text"/> <input type="text"/> Pinhole <input type="text"/> <input type="text"/> Corrected <input type="text"/> <input type="text"/> Near vision <input type="text"/> Colour vision <input type="text"/> <input type="text"/> Visual field Horizontal Vertical			
13.	Blood group			
Part IV: Certification and declaration				
Name and signature of the examining medical or health person		BMHC registration No. and Address:		
Person shall be certified unfit for driving if the person has:				

1. *Best corrected vision in both eyes worse than 6/12 (Private driving purpose)*
2. *Best corrected vision in both eyes worse than 6/9 (Professional driving purpose)*
3. *Best corrected vision worse than 6/12 and better than 6/60 (Restricted driving license)*
4. *Colour blindness*
5. *Visual field less than 120 horizontal and 20 vertical*
6. *Deafness(Severe)(Professional driving purpose)*
7. *Uncontrolled epilepsy (more than 3 episodes of seizures in the last 6 months)*
8. *Uncontrolled diabetes mellitus*
9. *Recurrent or disabling vertigo*
10. *Sever withdrawal syndrome*
11. *Major Mental disorders (severe depression, psychosis, manic episode in bipolar disorder, severe anxiety, attention deficit hyperactivity disorder, etc.)*

Form C: Medical Screening for Food Handlers

Part I and II of this form to be completed by the applicant:

Part I: Personal Information		
Name	Nationality	Passport No/Identity Card No./Voter Card No.
Date of Birth/Age	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Occupation
Residential Address in Bhutan:		
Contact Number:		

Part II: Medical History (To be declared and signed by the applicant)							
	Yes	No	If yes, give brief details		Yes	No	If yes, give brief details
1. Mental illness				2. Epilepsy			
3. Asthma/COPD/other allergies				4. Tuberculosis			
5. Hypertension				6. Liver diseases			
7. Heart Disease				8. Chronic skin diseases			
9. Addiction to drugs or alcohol				10. Blackouts and fainting attacks			
1. Recurrent bowel problem				12. Physical deformities			
1. Visual problem				14. Hearing Impairment			
I declare that all the information given above is correct and true. I also understand that I may be liable for actions by the concerned authority for providing false or misleading information.							
Signature of the applicant.....				Date.....			

Part III: Physical Examination: (to be completed by a registered medical or health person only)

A. General		Normal	Abnormal	Brief details (if Abnormal)
1.	Pulse rate..... Per min			
2.	Blood pressure/..... mm Hg			
3.	Conjunctiva (Circle) Pallor/non-icteric/others (specify)			
4.	Lymphadenopathy			
5.	Pedal oedema			
6.	Visible deformity			

B. Systemic				
7.	Nervous system (sensory and coordination)			
8.	Cardiovascular system			
9.	Respiratory system			
10.	Per abdomen- General Liver Spleen			
11.	Skin and nail conditions			
12.	Uro-genital conditions			
13.	Musculoskeletal systems			
Investigations				
12.	Visual acuity			
13.	Urine RE			
14.	Blood for hepatitis A, B and C			
15.	Stool RE			
16.	Blood/stool CS where indicated			
17.	Chest X-ray where indicated			
Part IV: Certification and declaration				
Name and signature of the examining medical or health person		BMHC registration No. and Address:		

Form D: Medical Examination for Non-Immigrant Work Permit



**Medical Examination for Non-Immigrant Work Permit
Department of Immigration
Ministry of Home and Cultural Affairs
Royal Government of Bhutan**



NOTES:

1. This medical examination requirement is in line with Immigration Act of the Kingdom of Bhutan
2. All expenses for medical examination must be borne by the applicant
3. The laboratory tests and chest x-ray must be conducted only in authorized health/diagnostic centers in Bhutan
4. The Medical Certificate is valid for two years from the date of issue
5. Non-immigrant workers with valid work permit absent from Bhutan for 30 days or more shall be required to undergo re-entry medical test/s as deemed necessary by the immigration office
6. This form should not be used for prescribing medicines

Part 1: Personal Information

Name:	Passport No/Identity Card No./Voter Card No.	Nationality
Occupation:	Date of Birth/Age	Sex
Address in Bhutan(Employer's name and company)		

Part II: Medical History (to be declared and signed by the applicant in the presence of/or with assistance of medical or health professional Y= YES; N=NO)

Medical Condition	Y	N	If yes, provide brief details	Medical Condition	Y	N	If yes, provide brief details
Mental illness				Epilepsy			
Asthma/COPD				Diabetes Mellitus			
Hypertension				Tuberculosis			
Heart Disease				Kidney Disease			
Addiction to drugs or alcohol				Prolonged or repeated hospital admission			
Major Surgical Operations				Long-term medication			
Visual &Hearing Impairment				Pregnancy			

I declare that all the information given above is correct and true. I also understand that providing false or misleading information may result in refusal of my application and cancellation of any work permit/visa issued

Signature/Thumb print of the applicant.....

Date.....

Note: it is an offence under the Immigration Act of the Kingdom of Bhutan to make any false statement, representation or declaration.

Part III: Physical Examination (to be conducted by the registered medical or health professionals)

A. General	Normal	Abnormal	If abnormal, give brief details
Pulse Rate per minute			
Blood Pressure mmHg			
Conjunctiva (circle): Pallor/ Non-icteric/Others (Specify):			
Vision: R L			
Lymphadenopathy			
Pedal Oedema			
Visible Deformity			
B. Systemic			
Skin: Hypo Pigmented patch			
Cutaneous Nerve Enlargement			
Cardiovascular system			
Per Abdomen/ liver/spleen			
Hernia			
Mental State (Sensory and Coordination)			
Respiratory System			

Part IV: Laboratory tests and Chest X-Ray (to be conducted at authorized health/diagnostic centres in Bhutan.)

Note: Original lab. test results and chest X-ray must be attached for verification by certifying medical professional

1.	Chest X-ray no. Date of X-ray..... Name of Health/Diagnostic centre: Remarks/Report.....
2.	Urine analysis: a) Albumin..... b) Sugar..... c) RBCs..... Name of Health/Diagnostic centre: Date of Test..... Remarks/Report.....
3.	Syphilis Serology: Result..... Date of Test..... Name of Health/Diagnostic centre:
4.	Blood for Malaria Parasite: Result..... Date of Test..... Name of Health/Diagnostic centre:

Part V: Certification and Declaration (to be completed by an authorized medical professional)

I certify that I have examined the applicant..... bearing passport/ID/voter card no..... and analysed his/her laboratory tests results and Chest X-ray report. I declare the applicant to be:

FIT

UNFIT*

Comments (if any) by the Examining Medical Or Health Professional

Examining Medical or Health Professional

Name and Address:

BMHC Registration no.

Signature and Official seal:

For Office Use Only

Fee (excludes laboratory and chest X-ray costs) Nu.

Receipt no.....

Payment received by (Name and signature).....

Date.....

Form E: Pre-Employment Medical Screening for Industrial Workforce

Instructions for applicants

All applicants who are being considered by a prospective employer for employment in the industries are required to undertake a pre-employment medical screening.

The following forms are required to be completed accurately and in full by both the applicant and the medical or health person prior to medical assessment and certification.

The completed forms must be returned to the prospective employer and a copy is retained with the issuing authority.

Photo

Section A: Applicant's report *(to be completed by the applicant)*

Part I: Personal detail

Surname _____	First Name _____
Nationality _____	DOB _____
Address _____	
Employer _____	Contact No. _____

Part II: Personal Medical History

	Yes	No	If yes, give details
Are you currently being treated by any doctor for any illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently taking any medications including inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you allergic to anything?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever spent time in hospital as a patient?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you broken or fractured any bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had a disease or injury resulting from work?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you suffer from back, neck or spinal problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you ever had an x-ray or scan of your neck or back?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you, in the last 2 years, lost time from work because of illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been exposed to any toxic substances or environmental hazards?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Part III: Do you now, or have you ever had any of the following? (Please tick box)

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Head injury or concussion
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Ear ache or discharging ears	<input type="checkbox"/>	<input type="checkbox"/>	Deep vein thrombosis
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hearing defects	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Passing blood in urine/stool
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/stress	<input type="checkbox"/>	<input type="checkbox"/>	Frequent migraine headaches
<input type="checkbox"/>	<input type="checkbox"/>	Palpitation /irregular heart beats	<input type="checkbox"/>	<input type="checkbox"/>	Other mental disorders	<input type="checkbox"/>	<input type="checkbox"/>	Other joint injuries or conditions
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ankle or knee troubles
<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Bruising or excessive bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain or loss
<input type="checkbox"/>	<input type="checkbox"/>	Back pain, back injury, sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Injury requiring an operation
<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease/bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or tumour of any kind
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/fits	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leprosy/TB/Kalazar

Comment: _____

Is there any history of serious disease or illness in your immediate family? **Yes** **No**

If yes please provide details when you see the doctor

Do you:

Yes **No**

- Smoke or have ever smoked. If yes, no. of cigarettes per day _____
- Take illicit drugs, if yes provide details _____
- Drink alcohol, if yes average number of standard drinks per week _____
- Have any illness or injuries not stated above, if yes provide details _____

Do you have difficulty in any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Crouching/bending/kneeling	<input type="checkbox"/>	<input type="checkbox"/>	Walking on uneven ground	<input type="checkbox"/>	<input type="checkbox"/>	Standing for an extended periods of time
<input type="checkbox"/>	<input type="checkbox"/>	Lifting heavy weights	<input type="checkbox"/>	<input type="checkbox"/>	Sitting for extended period of time	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive movements of hands/arms
<input type="checkbox"/>	<input type="checkbox"/>	Working at heights	<input type="checkbox"/>	<input type="checkbox"/>	Shift/work/sleep	<input type="checkbox"/>	<input type="checkbox"/>	Confined spaces
<input type="checkbox"/>	<input type="checkbox"/>	Walking upstairs/ladders	<input type="checkbox"/>	<input type="checkbox"/>	Working in hot/cold extremes	<input type="checkbox"/>	<input type="checkbox"/>	Working above shoulder height

When and where was your last chest x-ray taken? _____

When was your last tetanus injection? _____

Do you have or have ever had any other conditions not mentioned above that may impact on your ability to safely perform the duties required of you?

I hereby certify that the foregoing particulars are to the best of my knowledge correct. I authorizeto release any information acquired from this examination to my employer/ prospective employer or their authorized representative.

Signature and date _____

Signature of witness and date _____

Section B: Medical examination (to be completed by a registered medical or health person)

1. Measurements

Height _____ Weight _____ BMI(if required)_____

Visual acuity:

Distance vision

Eye	Uncorrected	Corrected
Right		
Left		
Both		

Close vision

Corrected	Uncorrected
N	N
N	N
N	N

Colour vision: Normal Abnormal

Blood pressure: mmHg Additional readings if required:.....

Pulse rate (resting pulse) per min; **Rhythm:** Regular Irregular

2. General:

- | | Yes | No | Provide details if required |
|--|--------------------------|--------------------------|-----------------------------|
| a) Does the appearance correspond with the age stated? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Is there anything unfavourable in appearance | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) Give particulars of permanent marks or scars | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| d) Any dermatitis, skin rash, infection | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| e) Any swelling/pitting pedal oedema | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

3. Respiratory system:

- | | Yes | No | Provide details if required |
|--|--------------------------|--------------------------|-----------------------------|
| a) Is breathing normal and regular in character? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Is there any abnormality on inspection or examination? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) See is there any sign of past or present respiratory disease. | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

4. Circulatory system:

- | | Yes | No | Provide details if required |
|--|--------------------------|--------------------------|-----------------------------|
| a) Are there any abnormalities on cardiac auscultation? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Is there any abnormality in the heart rate or rhythm? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) Is there any varicose veins? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

5. Digestive system:

- | | Yes | No | Provide details if required |
|---|--------------------------|--------------------------|-----------------------------|
| a) Is there evidence of abnormality of the tongue, mouth, teeth or throat? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Is there evidence of abnormality for abdominal organs, including liver and spleen? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) Is a hernia present? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

6. Spine and nervous system:

- | | Yes | No | Provide details if required |
|--|--------------------------|--------------------------|-----------------------------|
| a) Is there evidence of disease of the brain or spinal cord? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b) Is there any defect in sight, hearing or speech? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c) Is the evidence of abnormality for: | | | |
| Shoulder | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Elbows/wrist | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hand/hips | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Knees/ankles | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Feet | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cervical spine | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thoracic spine | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

- d) Reflexes:
Is there evidence of abnormality for:
- | | | | |
|-----------|--------------------------|--------------------------|-------|
| Biceps | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Triceps | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Supinator | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Knee | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ankle | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

7. Hearing Test: (Note the findings)

Ear	External appearance	Auroscopic exam	Rinne's test	Weber's test	Conversational hearing/whispering test	Audiometry (please attach report)
Right						
Left						

Normal Abnormal If abnormal, give details.....

8. For female candidates

- a) **Menstrual history:** Menarche at yrs (age) LMP
Menstrual irregularity, if any.....
- b) **Obstetric history:** Gravida Para.....
- c) **Pelvic examination** (for married women only).....
- d) **Pap smear**
- e) **Pregnancy test**.....

Investigations:

- a) Serological Examination
Hepatitis B..... Hepatitis C..... HIV..... RPR..... TPHA.....
Dengue..... H5N1 H1N1..... Others
- b) CBC
TLC DLC Hb
- c) ABO Rh.....
- d) Smear for malaria
- e) Urine analysis: Sugar Protein Blood
- f) Electrocardiogram (if required) Normal Abnormal Report attached
- g) Chest x-ray: Film No. Normal Abnormal Report attached
- h) Pulmonary Function test (where indicated):

	FVC	FEV1
Predicted		
Measured		
% of predicted		

Remarks:.....

- i) Additional investigations for persons over 40 years of age (male):
TMT
Echocardiogram
Ultrasound for prostate

Section C:

I am of the opinion that the above mentioned person is:

- Fit for proposed employment
 Fit for proposed employment with the following restrictions;

- Unfit for proposed employment

Signature and Name of the Medical or health person

BMHC Reg. No.

Official seal

Date: _____

Form F: Medical Assessment for Disability

Part I. PERSONAL INFORMATION

Name:.....Age/Sex:.....
Nationality:.....
CID /Passport/Voter ID/ Employee ID No.:.....
Occupation:.....Contact No.:.....
Address:

Part II. EMPLOYER DETAILS:

Name of Employer:.....
Employer’s address:.....

Part III. HISTORY OF INJURY /ILLNESS (from the worker):

Date of Injury / disease first noticed:
Workplace location where injury/disease occurred:
Description of how the injury or disease occurred:
Description of the injury or disease:
.....
.....

Part IV. MEDICAL ASSESSMENT:

Date & Time of Examination:.....Place of Examination:.....
Past Medical History (*relevant to the current condition as well as refer to the pre-employment medical condition*):
.....
.....
.....

Examination Findings:

- a. General physical examination:.....
.....
.....
- b. Systemic examination:.....
.....
.....
- c. Local examination:.....
.....
.....

Laboratory /Diagnostic Investigations:
.....
.....

Diagnosis:

V. MEDICAL MANAGEMENT PLAN:

Treatment:
.....
.....

Medication:.....
.....
.....

Referral to Hospital:.....
.....
.....

Referral to Specialist (specialty/ name):

Referral to Allied Health Professionals:

- (a) Physiotherapist
- (b) Vocational rehabilitation
- (c) Others:

Review Date: Worker to be reviewed on



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གསོ་བ་ལྷན་ཁབ།
ROYAL GOVERNMENT OF BHUTAN
Ministry of Health



Reg.

Medical Certificate

I certify that I have examined

Full name.....

Age/Sexbearing Citizenship ID/Passport /Voter card No.....on
(date).....as a candidate applying for (*Specify purpose*)

In my opinion, the person examined is (*check appropriate box*):

- 1. In a state of good physical and mental health, and there is nothing to disqualify him/her on medical grounds for the purpose for which this certificate is issued.
- 2. Not fit for the specified purpose applied.

Additional comments:

Signature of Certifier:.....

Name:

Designation:.....BMHC Reg. No.:

Date(*certificate is signed*):.....

Official seal

This certificate is valid for a period of six months from the date of issue.

The examining doctor should carry out pre-employment medical screening as indicated below:
For General purpose: form A; driving purposes: Form B; food handlers: Form C; expatriate workforce: Form D, industrial workforce: Form E



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གསོ་བ་ལྷན་ཁག།



ROYAL GOVERNMENT OF BHUTAN
Ministry of Health

Reg.No.....

Disability Certificate

I certify that I have examined

Full name.....
Age/Sexbearing Citizenship ID/Passport /Voter card No.....on
(date)..... who is employed asin
..... (Agency)

In my opinion:

A. CAUSE OF INJURY / ILLNESS: (tick appropriate cage):

- (a) Related to work (b) Not related to work (c) Of uncertain cause (comment):

B. NATURE OF DISABILITY*(tick appropriate cage):

- (a) Temporary partial: (b) Temporary total: (c) Permanent partial (d) Permanent total:

C. FITNESS FOR WORK (Tick those boxes which apply):

- (a) Fit to return to pre-injury duties, no further treatment required;
- (b) Fit to return to pre-injury duties, but requires further treatment;
- (c) Fit to return to work for restricted hours/days from: to
- (d) Fit to return to work on restricted duties from:
- Avoid prolonged standing/ walking/ sitting;
 - Avoid squatting/ kneeling/ ladders/ steps;
 - No lifting of heavy of objects;
 - Avoid repetitive use of affected body part;
 - Avoid repetitive bending/ lifting;
 - Other:
- (e) Unfit to work for
- (f) Unfit for present work

Signature of Certifying Practitioner:.....
Name:..... Designation:
BMHC Reg. No.: Health Centre:
Date (certificate is signed): Official Seal:.....

Medical Endorsement

After having discussed the patient's illness and medical interventions with the treating practitioner, we hereby endorse the opinion expressed by the certifying practitioner.

.....
.....
Signature of Treating Practitioner
Name/Designation/BMHC Reg. No.

.....
.....
Signature of Medical Practitioner
Name/Designation/BMHC Reg. No.

*** Note: The Medical assessment of disability relates to the physical impairment only. The employing agency or compensating agency must assess other aspects of disabilities such as social, vocational and psychological impairment.**

