Patient's Medical Evaluation form

Date of issuing the Form: __________________ (Must not excessed 48H from Discharge Date)
Date of discharge from Hospital: ____________ (Must not excessed 96H from the date of Departure to Oman)

1. Passenger details:

Passenger full name: ____
Age: _____ Gender: ________ Civil Number: ____________ Mobile Number: _______________
Home address in Oman: ______________________________________

2. Treating hospital:

Hospital Name: ____
Country: ________________ Province: ___________________
Address and contact number: _____________________________________
Date of admission (if applicable): _______________ Date of discharge (if applicable): _______________
(Please attached a copy of the Discharge Summary report of the patient)

3. Patient Status:

Patient is fit to take care of him/her self: □Yes □ No (If No State the reason below and fill the an accompanying Person)

State the reason

Patient needs an accompanying Person (s): {for Male patient (1) and Female/child (2) as per MoH-Oman}

1st Accompanying person[1]:	2nd Accompanying person:
i. Name:_____________________________	i. Name:_____________________________
ii. Civil Number: __________________	ii. Civil Number: ______________
iii. Mobile number: _____________________	iii. Mobile number: _____________________
iv. Home address: ______________________	iv. Home address: ______________________

I Dr. ___________________________ hereby declare that the information above is true, complete and correct to the best of my knowledge and belief. I understand that in the event of my information being found false or incorrect at any stage, a legal action will be taken against me and my employing institution.

Dr. Name:
Signature and stamp:

Hospital Stamp

[1] The accompanying person is the person whom is eligible for exemption by proxy.