APPLICANT HEALTH ASSESSMENT (AHA) FORM
(ACADEMIC YEAR 2025-2026)

The training history and health assessment provides basis of pre-training evaluation for all applicants joining Oman Medical Specialty Board. Continued postgraduate training contract is dependent on the successful AHA completion.

The purpose of the form is to determine whether you have health conditions that could affect your ability to undertake the duties of the training you have been offered or places you at risk in the workplace. It may be that adjustments or support is recommended as a result of this assessment to enable you to complete your training. Our aim is to promote and maintain the safety and the health of OMSB trainees, patients and staff.

The information that you will provide will be confidential to OMSB and will not be given to anyone else without your written permission. We do use anonymized information for audit purposes, which will not reveal confidential information in any audit report.

The AHA form has two (2) parts to be completed and submitted with your application.

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PART I – Applicant Health Assessment Questions:

No.	Question	Yes/ No
1.	Do you currently have any health condition/impairment/disability (physical or psychological)?	
2.	Have you ever had any health condition/impairment/disability in the past?	
3.	Are you having, or waiting for treatment (including medication) or investigation for any health condition/impairment/disability (physical or psychological)?	
4.	Do you have an infectious disease that can interfere with your work as a clinician?	
5.	Do you need any adjustments or assistance to help you to undergo the training?	

If yes to any of the above questions, please specify details of the condition, treatment and dates.
(For more space, please add a separate attachment to this form)

Do you have any additional information related your health? If YES, please specify.

How much time have you lost from work/college due to illness during the last 2 years?

PART II: Follow-up Healthcare Committee (Laboratory Investigation)

Name of Applicant: **Mobile Number:** **National ID:**
Gender: **Date of Birth:**

IMMUNIZATION ASSESSMENT & BLOOD TESTS SECTION	
1	**Vaccination Record/Immunization Report (administered at least 2 doses)** a) MMR: Complete Immunization: ☐ Yes ☐ No b) Varicella: Complete Immunization: ☐ Yes ☐ No Date of Test:
2	**Hepatitis B Serology** a) HBs-Ag: Positive ☐ Negative ☐ b) Anti-HBc: Positive ☐ Negative ☐ c) Anti-HBs (> 10IU/ml): Immune ☐ Non-Immune ☐ Date of Test:
3	**Hepatitis C Serology** a) Anti-HCV: Positive ☐ Negative ☐ Date of Test:
4	**HIV Antigen & Antibody Screening Test** Positive ☐ Negative ☐ Date of Test:
5	**TB Quantiferon-Gold** Positive ☐ Negative ☐ Date of Test:
6	Normal Test ☐ Abnormal Test ☐

Physician Healthcare Officer In-charge:

Name: ______________________________ Signature: ______________________________

Date: ______________________________ Stamp: ______________________________

****Immunization records and serology reports should be attached to the Acknowledgment Form with the validity of reports of at least one (1) year upon application to OMSB*.**

ACKNOWLEDGEMENT

I certify that, to the best of my knowledge and belief, all of the information in this form and/or attached to it, is true, correct, and accurate.

I understand that a false or fraudulent answer to any question or item to any part of this form or its attachments may be grounds for not accepting my registration as an OMSB trainee or for termination from a training program at a later date after acceptance and during my training.

I give consent for my health records to be reviewed, including vaccinations and blood results to be used for assessment by OMSB Follow-up HealthCare committee or other concerned parties, as required.

I understand that any information I give may be investigated for purposes of determining eligibility for OMSB training programs.

I consent to the release of information about my ability and fitness for training by OMSB to authorized personnel or representatives of the OMSB if needed while protecting confidentiality with anonymous processes.

I understand that if any recommendations to my sponsor are necessary as a result of this AHA, OMSB will discuss the recommendations with me, and may disqualify me from joining OMSB.

☐ **I Agree**

Name of Applicant: ____

Date of Birth: ____

National ID Number: ____

Date: ____

Signature: ____