APPLICANT HEALTH ASSESSMENT (AHA) FORM

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 three (3) 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.

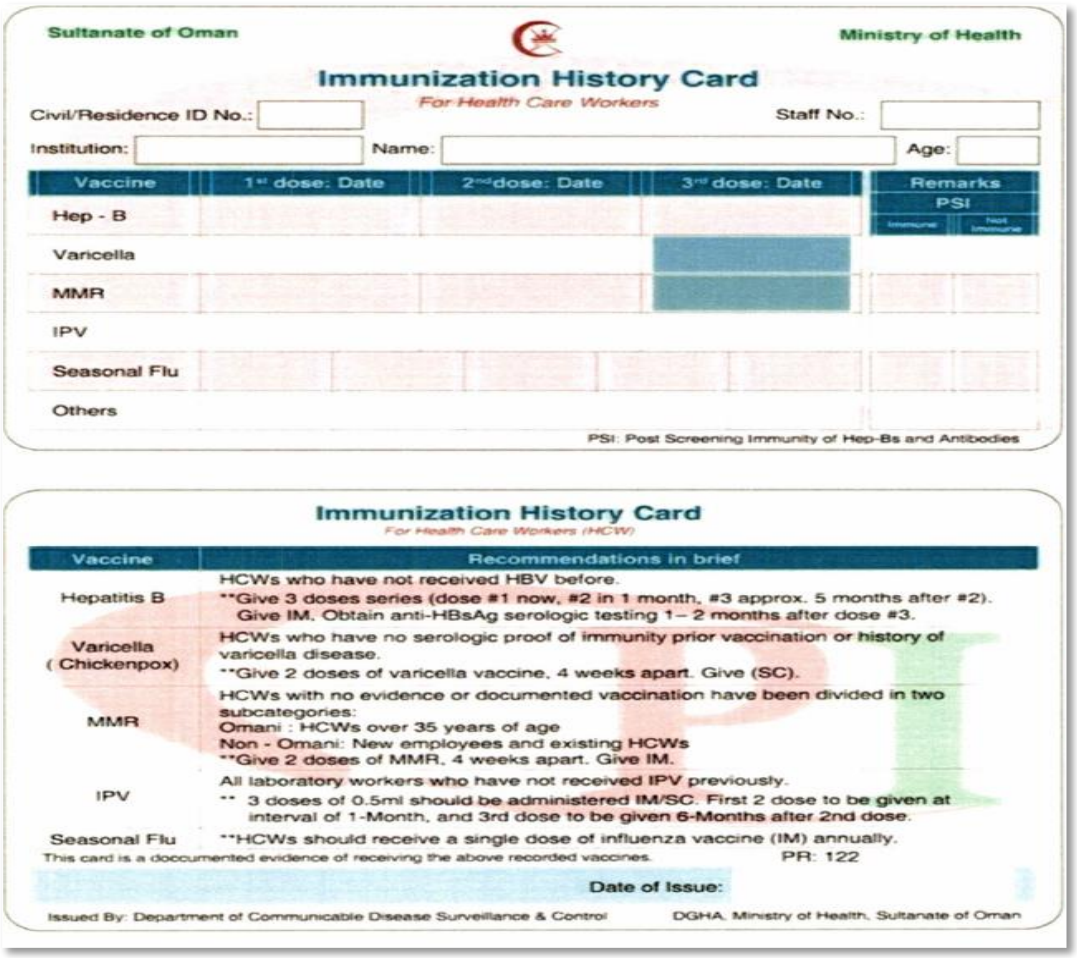
How much time have you lost from work/college due to illness during the last 2 years?

PART II: BLOOD TESTS ASSESSMENT

TESTS	Positive/Negative
HIV Serology	
HCV RNA	
HBsAg	
Tuberculin Skin Test (TST)	

PART III: IMMUNIZATION ASSESSMENT

As per the national guidelines of the immunization for workers, residents, trainees & students in the Health Care, please provide your vaccinations listed in the Immunization History Card below:



Sultanate of Oman — Ministry of Health

Immunization History Card

For Health Care Workers

Civil/Residence ID No.: Staff No.:

Institution: Name: Age:

Vaccine	1st dose: Date	2nd dose: Date	3rd dose: Date	Remarks PSI (Immune / Not Immune)
Hep - B				
Varicella				
MMR				
IPV				
Seasonal Flu				
Others				

PSI: Post Screening Immunity of Hep-Bs and Antibodies

Immunization History Card

For Health Care Workers (HCW)

Vaccine	Recommendations in brief
Hepatitis B	HCWs who have not received HBV before. **Give 3 doses series (dose #1 now, #2 in 1 month, #3 approx. 5 months after #2). Give IM. Obtain anti-HBsAg serologic testing 1– 2 months after dose #3.
Varicella (Chickenpox)	HCWs who have no serologic proof of immunity prior vaccination or history of varicella disease. **Give 2 doses of varicella vaccine, 4 weeks apart. Give (SC).
MMR	HCWs with no evidence or documented vaccination have been divided in two subcategories: Omani : HCWs over 35 years of age Non - Omani: New employees and existing HCWs **Give 2 doses of MMR, 4 weeks apart. Give IM.
IPV	All laboratory workers who have not received IPV previously. ** 3 doses of 0.5ml should be administered IM/SC. First 2 dose to be given at interval of 1-Month, and 3rd dose to be given 6-Months after 2nd dose.
Seasonal Flu	**HCWs should receive a single dose of influenza vaccine (IM) annually.

This card is a documented evidence of receiving the above recorded vaccines. PR: 122

Date of Issue:

Issued By: Department of Communicable Disease Surveillance & Control DGHA, Ministry of Health, Sultanate of Oman

ACKNOWLDGMNET

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: _____

***Note:**

Category One (1) – Interns inside Oman and GFP: Please attach your pervious medical reports of the above-mentioned immunization records and blood tests reports together with this from; if not available provide new reports.

Category Two (2) - Interns outside Oman and General Practitioners (GPs): Please attach your medical reports of the above-mentioned immunization records and blood tests reports together with this from.