

APPLICANT HEALTH ASSESSMENT (AHA) FORM

(ACADEMIC YEAR 2027-2028)

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.

PART I – Applicant Health Assessment Questions:

SN	QUESTIONS	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 undergo the training?	

If you answered **YES** to any to any of the above questions, please specify details of the condition, treatment (if any), and relevant dates. If additional space is required, please attached a separate sheet.

Do you have any additional information related to your health that you wish to disclose? If **YES**, please provide the details below:

Please indicate the total amount of time (if any) you have been absent from work or college due to illness during the **past two (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 MEASLES, MUMPS, RUBELLA, VARICELLA: VACCINES **OR** SEROLOGY****a) MMR:**You meet the requirement if you have **ONE** of the following:

1. Documented evidence of **TWO** doses of MMR vaccination at least 4 weeks apart
2. A laboratory report showing a **positive IgG antibody result** for Measles, Mumps, and Rubella in the past

If documentation cannot be provided and there are no contraindications, **two (2) doses of MMR vaccine (four weeks apart) are required and no new laboratory testing is needed.*

b) Varicella:You meet the requirement if you have **ONE** of the following:

1. Documented evidence of **TWO** doses of Varicella vaccination at least 4 weeks apart
2. A laboratory report showing a **positive Varicella IgG antibody result** in the past

If documentation cannot be provided and there are no contraindications, **two (2) doses of Varicella vaccine (four weeks apart) are required and no new laboratory testing is needed.*

	Date of vaccine 1	Date of vaccine 2		Report for IgG antibody serology attached
Measles			OR	☐
Mumps			OR	☐
Rubella			OR	☐
Varicella			OR	☐

2	Hepatitis B Serology (within 6 months) a) Hepatitis B Surface Antigen (HBs-Ag): Positive ☐ Negative ☐ b) Hepatitis B core total Antibody (Anti-HBc): Positive ☐ Negative ☐ c) Hepatitis B Surface Antibody (Anti-HBs) (> 10IU/ml): Immune ☐ Non-Immune ☐ <i>*If there is documentation of a completed Hepatitis B vaccine series (3 doses) AND an Anti-HBs level >10 IU/mL, repeat Hepatitis B serology is not required</i> Date of Test:
3	Hepatitis C Serology (within the last 6 months) d) Hepatitis C Antibody (Anti-HCV): Positive ☐ Negative ☐ Date of Test:
4	HIV Antigen & Antibody Screening Test (within the last 6 months) Positive ☐ Negative ☐ Date of Test:
5	TB Quantiferon-Gold (within the last 12 months) Positive ☐ Negative ☐ Date of Test:
6	Normal Test ☐ Abnormal Test ☐

PART III: Verification and Certification

This section is to be completed by the Physician Healthcare Officer In-charge:

Applicant's Identity Verified: Yes ☐ No ☐

Name: _____

Signature: _____

Date: _____

Stamp: _____

*Immunization records and serology reports should be attached to the Acknowledgment Form

**Applicants are required to attend an identified healthcare provider for the collection of validated specimens for laboratory testing

ACKNOWLEDGEMENT

I hereby declare that all information provided in this form and in any attached document is true, complete, and correct to the best of my knowledge and belief.

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: _____