MEGA MANPOWER CORPORATION
MIDDLE EAST DIVISION

We got you JOBS OVERSEAS

License No. : DMW-452-LB-09302024-R
Rooms 501 & 502 Gedisco Terrace,
1148 Roxas Blvd. Ermita, Manila
Website : www.megamanpower.com

Tel. no. : (02) 8522 6657 / 8772 8978
Whatsapp : +63 921 989 7863
Email : info@megamanpower.com
FB Page : /MegaMiddleEastDivision

INTERVIEW RATING SHEET

POSITION APPLIED		DATE	

PERSONAL INFORMATION

NAME				CONTROL NO.	
	LAST	FIRST	MIDDLE	RELIGION	
HIGHEST EDUCATION				DATE OF BIRTH	
NO. OF YEARS OF EXPERIENCE	LOCAL		ABROAD	AGE	

MEDICAL EQUIPMENTS HANDLED

REMARKS	VERIFICATION DETAILS

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POSITION (1st Choice) ▶	

PERSONAL INFORMATION

NAME ▶				Date Applied ▶	
	Last ▲	First ▲	Middle ▲	Religion ▶	
Highest Education ▶				Date of Birth ▶	
No. of Years of Experience ▶	Local ▶		Abroad ▶	Age ▶	

Complete City Address ▶		FB Account ▶	
		Landline No. ▶	
Complete Provincial Address ▶		Cellphone No. ▶	
		Whatsapp No. ▶	
E-mail Address ▶		Gender ▶	☐ Male ☐ Female
Civil Status ▶	No. of Children ▶	Weight ▶	Height ▶
Name of Spouse ▶		Date of Birth ▶	
Name of Father ▶		Date of Birth ▶	
Name of Mother ▶		Date of Birth ▶	

EDUCATIONAL ATTAINMENT

NAME OF SCHOOL		YEAR From ▼ - To ▼	DEGREE / COURSE ▼
High School ▶			
Vocational ▶			
College/University ▶			
Masteral ▶			

WORK EXPERIENCE (Present to Previous)

Company Name ▶		Agency ▶	
Company Address ▶		Contact Number ▶	
Position ▶		From ▶ mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶		Salary ▶	

Company Name ▶		Agency ▶	
Company Address ▶		Contact Number ▶	
Position ▶		From ▶ mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶		Salary ▶	

Company Name ▶		Agency ▶	
Company Address ▶		Contact Number ▶	
Position ▶		From ▶ mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶		Salary ▶	

WORK EXPERIENCE (Present to Previous)

Company Name ▶		Agency ▶	
Company Address ▶		Contact Number ▶	
Position ▶		From ▶ mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶		Salary ▶	

Company Name ▶		Agency ▶	
Company Address ▶		Contact Number ▶	
Position ▶		From ▶ mo. - day - year	To ▶ mo. - day - year
Reason for Leaving ▶		Salary ▶	

OTHER INFORMATION

Special Skills ▶			
Special Equipment and Test Instrument you can Operate ▶			
Computer Application / Software you can Operate ▶			
Organization Affiliations ▶			
PRC License Number ▶		Passport Number ▶	
PRC Profession ▶		Passport Date of Issuance ▶	
PRC Rating ▶		Passport Expiry Date ▶	
PRC Date Issuance ▶		Saudi Council License Number ▶	
PRC Expiry Date ▶		Saudi Council License Expiry Date ▶	
NBI Clearance Expiry Date ▶		SSS/GSIS Number ▶	
Pag-ibig Number ▶		Drivers License No. ▶	
Philhealth Number ▶		Drivers License Expiry Date ▶	

NAME OF PERSON TO CONTACT IN CASE OF URGENT MESSAGE

Name ▶			Date of Birth ▶		
Relationship ▶		Landline No. ▶		Cellphone No. ▶	
Address ▶			Email Address ▶		

HOW DID YOU LEARN ABOUT THE VACANCY? (Facebook, friends, relative, etc.) ▶

DATA PRIVACY AGREEMENT

I,_____, hereby declare that I am applying for _____ as _____ and that all personal information and documents I have provided in connection with my application are true and accurate. I authorize **Mega Manpower Corporation** to verify the authenticity and validity of my documents and to collect, process, and use my personal information solely for the purpose of evaluating and processing my overseas employment application, in accordance with applicable data privacy laws and regulations.

I understand and voluntarily consent to the verification and processing of my personal information and documents for the purposes stated above.

_____

Signature of Applicant ▲

MEDICAL QUESTIONNAIRE

MEGA MANPOWER CORPORATION
We got you JOBS OVERSEAS

INSTRUCTIONS:

Please complete this questionnaire fully and accurately. All questions must be answered.

All information will be treated as strictly confidential. You are responsible for ensuring that the information provided is complete and truthful. Failure to disclose relevant information or providing false or misleading information may affect your employment or medical clearance.

1. APPLICANT INFORMATION

Name (Last, First, Middle Name): _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female **Height:** _____ **Weight:** _____

2. MEDICAL CONDITIONS, SYMPTOMS, VISION, HEARING AND SPECIAL NEEDS

Instructions: Please tick YES or NO for each question. If **YES**, provide relevant details where indicated.

A. Medical Condition and Health History

Yes	No	Condition / Illness
☐	☐	• Lung or respiratory disease, including asthma or tuberculosis (TB)
☐	☐	• Heart disease, hypertension, stroke or circulation disorder
☐	☐	• Diabetes or other endocrine/metabolic disorder
☐	☐	• Thyroid disease
☐	☐	• Kidney, liver or gastrointestinal disease
☐	☐	• Hepatitis or other significant infectious disease
☐	☐	• Neurological disorder, epilepsy or seizures
☐	☐	• Cancer, blood disorder or autoimmune disease
☐	☐	• HIV infection
☐	☐	• Significant sexually transmitted infection
☐	☐	• Leprosy (Hansen's disease)
☐	☐	• Mental or behavioral health condition
☐	☐	• Bone, joint, muscle or spinal condition
☐	☐	• Scoliosis or other physical deformity/impairment
☐	☐	• Physical deformity, amputated finger, limb loss or significant scar
☐	☐	• Congenital condition or birth defect

Yes	No	Condition / Illness
☐	☐	• Cleft lip and/or cleft palate
☐	☐	• Limited movement or muscle weakness
☐	☐	• Difficulty walking, standing or climbing stairs
☐	☐	• Difficulty bending, lifting or carrying
☐	☐	• Difficulty using hands/fingers or maintaining balance
☐	☐	• Use of wheelchair, prosthesis, orthotic or other assistive device
☐	☐	• Skin condition, including eczema, psoriasis or other chronic skin disease
☐	☐	• Polio or post-polio condition
☐	☐	• Allergies (medication, food or other significant allergy)
☐	☐	• Severe allergic reaction/anaphylaxis
☐	☐	• Tattoos, body piercings or other body modifications
☐	☐	• Other significant medical condition _____

B. Vision, Color Vision and Hearing

Yes	No	Condition / Question
☐	☐	• Have you been diagnosed with abnormal color vision/ Ishihara?
☐	☐	• Do you have a hearing impairment or use a hearing aid?
☐	☐	• Do you have any speech or communication difficulty?

Yes	No	Condition / Question
☐	☐	• Do you wear glasses or contact lenses?
☐	☐	• Do you have a visual impairment or eye disease?

If YES, please provide details or known test results: _____

C. Current Symptoms and Special Needs

Yes	No	Condition / Need
☐	☐	• Do you currently have a fever, persistent cough or breathing difficulty?
☐	☐	• Do you experience chest pain, palpitations, fainting or severe dizziness?
☐	☐	• Have you had significant unexplained weight loss or persistent fatigue?
☐	☐	• Do you currently have significant pain or other serious symptoms?

Yes	No	Condition / Need
☐	☐	• Do you require regular medical treatment while abroad?
☐	☐	• Do you require medical equipment or special assistance while abroad?
☐	☐	• Do you have a health condition that may affect your intended work?

If YES, please provide details : _____

D. Other Medical Conditions

Yes	No	
☐	☐	• Have you ever had, or do you currently have, any other significant medical condition not listed above?

If YES, please specify the condition and current status: _____

3. SURGERY, HOSPITALIZATION, TREATMENT AND MEDICATION

Instructions: Please tick YES or NO for each question. If **YES**, provide relevant details where indicated.

Yes	No	Medical History
☐	☐	• Have you previously been hospitalized?
☐	☐	• Have you previously undergone surgery or a major medical procedure?
☐	☐	• Have you undergone thyroid surgery or radioactive iodine treatment?
☐	☐	• Have you undergone gender-affirming or other gender-related medical procedure?

Yes	No	Medical History
☐	☐	• Are you currently receiving medical treatment?
☐	☐	• Are you currently taking prescription medication?
☐	☐	• Are you currently taking mental health medication?
☐	☐	• Are you currently taking hormone medication/ hormone therapy?
☐	☐	• Do you regularly take any medication?

If YES, please provide details:

Condition/Reason: _____ **Dosage/Frequency:** _____

Medication/Treatment: _____ **Current Status:** _____

4. APPLICANT'S DECLARATION

I declare that the information provided in this questionnaire is t**rue, complete and accurate to the best of my knowledge.** I understand that additional medical examinations, tests or supporting documentation may be required depending on the destination country, employer, occupation or applicable visa/medical requirements.

I understand that I am responsible for providing accurate and complete information and for disclosing any relevant medical condition, treatment or medication.

Applicant's Name : _____ **Date** : _____

Signature : _____