

CAYMAN ISLANDS IMMIGRATION DEPARTMENT
MEDICAL EXAMINATIONS FORM



CAYMAN ISLANDS IMMIGRATION DEPARTMENT
GUIDELINES TO MEDICAL PRACTITIONERS

1. Medical examinations are required on initial application for work permit and once in every three years thereafter. The Immigration Department reserves the right to require medical examinations at any time.
2. Laboratory tests have to be repeated with each medical examination. Chest X-rays are required once in every five years. For practical purposes, for renewal application a chest x-ray is not required if the previous x-rays were done within 4 years of application.
3. Laboratory reports have to be attached for HIV and VDRL tests.
4. Medical practitioners are advised to perform any tests that might be desirable depending on the disease prevalence in the respective countries.

PART 1
QUESTIONNAIRE
(TO BE COMPLETED BY APPLICANT)

1. _____
 (a) Name (last) (First) (Middle)

 (b) Date of Birth (c) Place of Birth (d) Nationality (e) Passport/ID Number
 (f) Widowed Single Married Divorced Separated
2. HAVE YOU EVER HAD OR CURRENTLY HAVE YES NO
- (a) Nervous or mental trouble?
- (b) Fits or convulsions?
- (c) Heart trouble or raised blood pressure?
- (d) Lung tuberculosis, Asthma or hay fever?
- (e) Contact with a case of tuberculosis?
- (f) Frequent or prolonged indigestion?
- (g) Malaria, dysentery or any other tropical illness?
- (h) A sexually transmitted disease?
- (i) Eye trouble?
- (j) Any serious operation?
- (k) Diabetes?
- (l) Rheumatic Fever?
- (m) Family history of mental trouble, suicide, fits, any kind of tuberculosis, diabetes or raised blood pressure?
- (n) Any illness or injury not mentioned above?
- (o) A physical defect?
3. Do you take alcohol or habit forming drugs?
4. Have you ever applied for or received disability benefits?

If you have answered yes in questions 2,3 or 4, please provide details

- _____
5. Are you now in good health? Yes No If no, give details _____
6. Are you now pregnant? Yes No Not Applicable If yes, how many months _____

Date: _____ Signature of Applicant _____

Date: _____ Medical Examiner _____

PART II
MEDICAL EXAMINATION
(TO BE COMPLETED BY MEDICAL EXAMINER)

1. Is the Examinee personally known to you? Yes No
 If no, did you check ID? Yes No

2. Height _____ feet _____ in. Weight _____ lbs. (in under
 clothes) Waist _____ in.
 Chest measurements on respiration _____ in, on expiration _____ in.

3. Blood pressure (two readings: at rest(sitting) _____ lying down _____
) 4. Pulse rate _____

5. Date and report of last E.C.G. if any _____

6. Are the following free from any pathological condition or abnormality;

| | Yes | No | | Yes | No |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Skin | <input type="checkbox"/> | <input type="checkbox"/> | g. Cardiovascular System | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Throat & Mouth | <input type="checkbox"/> | <input type="checkbox"/> | h. Respiratory System | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Eyes | <input type="checkbox"/> | <input type="checkbox"/> | i. Locomotor System | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Ears | <input type="checkbox"/> | <input type="checkbox"/> | j. Nervous System | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Nose | <input type="checkbox"/> | <input type="checkbox"/> | k. Genito-Urinary System | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Abdomen | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If you answered "no" to any of the above questions, please provide details

.....

7. Is the examinee on any drug therapy at present? _____ if yes, give details

.....

8. Give details of any operations:

.....

9. Medical conditions a) _____ b) _____
 c) _____ d) _____

Signature Medical Examiner

Date of Examination

PART III
XRAY AND LABORATORY INVESTIGATIONS
(TO BE COMPLETED BY MEDICAL EXAMINER)

(a) Hospital Xray No. _____ Date _____ Result _____
 (Must have been done within 6 months of initial application and within 4 years of renewal application)

(b) Urine: Date _____ Albumin _____ Sugar _____

(c) Blood Tests (attach laboratory reports)

| TESTS | DATE | RESULT |
|------------|------|--------|
| VDRL | | |
| HIV SCREEN | | |
| | | |

(Test must have been done within 3 months of application. The Immigration Department reserves the right to request application to repeat these tests in the Cayman Islands)

(d) Other tests (depending on history and disease prevalence in the country of origin)

| TESTS | DATE | RESULT |
|-------|------|--------|
| | | |
| | | |
| | | |

Name and address of Medical Examiner in BLOCK Capitals

Qualifications _____ Medical Registration Number _____

Address of Registering body

Signature of Medical Examiner _____ Date _____

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