



# IMMIGRATION CAYMAN ISLANDS

## CAYMAN ISLANDS IMMIGRATION DEPARTMENT GUIDELINES TO MEDICAL PRACTITIONERS

### MEDICAL EXAMINATIONS FORM

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.

MEDICAL FORM CONTAINS 3 PAGES

### PART 1

QUESTIONNAIRE (TO BE COMPLETED BY APPLICANT)

1. (a) Surname (Last Name) \_\_\_\_\_ Maiden Name \_\_\_\_\_ Given Names (First Names) \_\_\_\_\_  
 (b) Nationality \_\_\_\_\_ (c) Country of Birth \_\_\_\_\_ (d) Date of Birth \_\_\_\_\_ (e) Passport number \_\_\_\_\_  
 (f) Marital Status Married  Divorced  Separated  Widowed  Single

2. Have You Ever Had Or Currently Have

	Yes	No
(a) Nervous or mental trouble	<input type="checkbox"/>	<input type="checkbox"/>
(b) Fits or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Heart trouble or raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Lung tuberculosis, Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Contact with a case of tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Frequent or prolonged indigestion?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Malaria, dysentery or any other tropical illness?	<input type="checkbox"/>	<input type="checkbox"/>
(h) A sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
(i) Eye trouble?	<input type="checkbox"/>	<input type="checkbox"/>
(j) Any serious operation?	<input type="checkbox"/>	<input type="checkbox"/>
(k) Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
(l) Rheumatic Fever?	<input type="checkbox"/>	<input type="checkbox"/>
(m) Family history of mental trouble, suicide, fits, any kind of tuberculosis, diabetes or raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
(n) Any illness or injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
(o) A physical defect?	<input type="checkbox"/>	<input type="checkbox"/>

3. Do you take alcohol or habit forming drugs?  Yes  No

4. Have you ever applied for or received disability benefits?  Yes  No

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 \_\_\_\_\_

# MEDICAL EXAMINATIONS FORM

## PART 2

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 \_\_\_\_\_

4. Date and report of last E.C.G. if any \_\_\_\_\_

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

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

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

6. Is the examinee on any drug therapy at present?  if yes, give details \_\_\_\_\_

7. Give details of any operations \_\_\_\_\_

8. Medical conditions a) \_\_\_\_\_ b) \_\_\_\_\_  
c) \_\_\_\_\_ d) \_\_\_\_\_

Date of Examination \_\_\_\_\_ Signature Medical Examiner \_\_\_\_\_

# MEDICAL EXAMINATIONS FORM

## PART 3

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 \_\_\_\_\_

Date of Examination \_\_\_\_\_ Signature Medical Examiner \_\_\_\_\_

### FOR OFFICIAL USE ONLY

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_