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 (See online guidelines for a list of approved laboratories in the Cayman Islands).

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	☐	☐
(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 _____

MEDICAL EXAMINATIONS FORM

PART 2

MEDICAL EXAMINATION (TO BE COMPLETED BY MEDICAL EXAMINER)

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

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	☐	☐
(b) Throat & Mouth	☐	☐
(c) Eyes	☐	☐
(d) Ears	☐	☐
(e) Nose	☐	☐
(f) Abdomen	☐	☐
(g) Cardiovascular System	☐	☐
(h) Respiratory System	☐	☐
(i) Locomotor System	☐	☐
(j) Nervous System	☐	☐
(k) Genito-Urinary System	☐	☐

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

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