



DEPARTMENT OF IMMIGRATION
 Government of the Virgin Islands
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 Tortola, British Virgin Islands
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GUIDELINES TO MEDICAL PRACTITIONERS

MEDICAL EXAMINATIONS FORM

1. Medical examinations are required with the initial work permit application. The Medical examinations are valid for three (3) years.
2. The Laboratory Reports are valid for six (6) months.
3. Chest X-rays are required with the initial work permit application. Chest Xrays are valid for ve (5) years.
4. Laboratory Reports have to be attached.
5. Medical practitioners are advised to perform any tests that might be desirable depending on the disease prevalence in the respective countries.
6. The Medical Examinations Form must be signed and stamped or sealed by Physician.
7. The Laboratory Report must be signed and stamped or sealed by Lab Technician or Physician.
8. Immigration reserves the right to require additional medical examinations at any time.

MEDICAL FORM CONTAINS 3 PAGES

PART 1 - QUESTIONNAIRE (to be completed by Applicant)

1. (a) Surname (Last Name) _____ Given Names (First Names) _____ Maiden Name _____
 (b) Nationality _____ (c) Country of Birth _____ (d) Date of Birth (dd-mm-yy) _____ (e) Passport No. _____
 (f) Gender Male Female (g) Marital Status Married Divorced Separated Widowed Single

2. Have You Ever Had Or Currently Have

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

If you have answered Yes to any part of questions 2, explain _____

3. Do you consume alcohol? Yes No
 If Yes, how many alcoholic drinks do you typically consume in 1 week _____

4. Do you take habit forming drugs? Yes No
 If Yes, explain _____

5. Have you ever applied for or received disability benefits? Yes No
 If Yes, explain _____

6. Are you now in good health? Yes No If No, give details _____

7. Are you now pregnant? Yes No Not Applicable If Yes, how many months _____

Date (dd-mm-yy) _____ Signature of Applicant _____ Original Signature Required _____

Date (dd-mm-yy) _____ Medical Examiner/Physician _____

MEDICAL EXAMINATIONS FORM

BRITISH VIRGIN ISLANDS IMMIGRATION DEPARTMENT GUIDELINES TO MEDICAL PRACTITIONERS

PART 2 - MEDICAL EXAMINATION (to be completed by Medical Examiner)

1. Is the Examinee personally known to you?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If No, did you check ID?	<input type="checkbox"/>		<input type="checkbox"/>

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 _____ 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 No to any of the above questions, provide details _____

6. Is the examinee on any drug therapy at present? Yes No If Yes, give details _____

7. Give details of any operations _____

8. Medical conditions _____ b) _____

c) _____ d) _____

Date of Examination (dd-mm-yy) _____ Signature Medical Examiner _____

MEDICAL EXAMINATIONS FORM

BRITISH VIRGIN ISLANDS IMMIGRATION DEPARTMENT GUIDELINES TO MEDICAL PRACTITIONERS

PART 3 - XRAY AND LABORATORY INVESTIGATIONS (to be completed by Medical Examiner)

(a) Hospital Xray No. _____ Date _____ Result _____

(b) Urine: Date _____ Albumin _____ Sugar _____

(c) Blood Tests (attach laboratory reports)

TESTS	DATE	RESULT
CBC	_____	_____
SMAC 20	_____	_____

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

TESTS	DATE	RESULT
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name and address of Medical Examiner

Qualifications _____ Medical Registration Number _____

Address of Registering body _____

Date of Examination (dd-mm-yy) _____ Signature Medical Examiner _____

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