DEPARTMENT OF IMMIGRATION
Government of the 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	☐	☐	(i) Eye trouble?	☐	☐
(b) Fits or convulsions?	☐	☐	(j) Any serious operation?	☐	☐
(c) Heart trouble or raised blood pressure?	☐	☐	(k) Diabetes?	☐	☐
(d) Lung tuberculosis, Asthma or hay fever?	☐	☐	(l) Rheumatic Fever?	☐	☐
(e) Contact with a case of tuberculosis?	☐	☐	(m) Family history of mental trouble, suicide, ts, any kind of tuberculosis, diabetes or raised blood pressure?	☐	☐
(f) Frequent or prolonged indigestion?	☐	☐			
(g) Malaria, dysentery or any other tropical illness?	☐	☐	(n) Any illness or injury not mentioned above?	☐	☐
(h) A sexually transmitted disease?	☐	☐	(o) A physical defect?	☐	☐

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)

	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 _____ 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 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 _____

FOR OFFICIAL USE ONLY

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