ANNEX D
MEDICAL CERTIFICATE FOR BRITISH FORCES SOUTH ATLANTIC ISLANDS
9 months to 4 years

Introduction

1. The information in this section will help you complete this certificate. Please read the information below before you start to complete this certificate.

2. If you live in the UK or the Falkland Islands your own General Practitioner (GP) can complete the form.

3. If you live outside the UK or the Falkland Islands you will need to have the form completed by an approved panel physician. Panel physicians are doctors who have been approved by the Falkland Islands Government to undertake this medical examination. A list of approved panel physicians is at Annex C but if a more recent list is required please contact the Falklands Immigration Department.

4. If you live in a country which does not have any panel physicians, a registered medical practitioner, preferably your own GP, can complete this certificate.

5. Your responsibilities:

   a. You must pay the fees for the immigration medical examination, any tests required and all postage and courier fees.

   b. You must tell the truth. False statements on a medical certificate result in your application being declined, any permit granted being cancelled and if you are in the Falkland Islands, you being required to leave the country.

BFSAI Full Medical Certificate

6. There are ten parts to the BFSAI Full Medical Certificate:

   a. Section A – Personal Details.

   b. Section B – Medical History.

   c. Section C – Declaration of Person Having the Medical Examination.

   d. Section D – Physical Examination.

   e. Section E – Urinalysis and Blood Tests.

   f. Section F – Examining Doctor's Summary of Findings.

   g. Section G – Examining Doctor's Declaration.

h. Section H – Confirmation of Identity and Declaration.

i. Section I – Declaration from BFSAI Senior Medical Officer.

Notes on Completion of the Forms:

7. The form should be completed in English. A Spanish version can be made available on request.

8. The Medical History section (Section B) must be completed by the examining doctor or delegated person. If you are not sure about an aspect of your medical history, declare it.

9. The physician will complete the physical examination. They will check your height, weight, mental state, hearing and vision, listen to your heart, lungs, feel your abdomen and check your reflexes, power and the rest of your nervous system.

10. Some parts of the physical examination may be completed by a nurse or health care assistant.

11. You will need to provide a urine sample during the immigration medical examination.

12. You will also need to get blood tests.

13. A chest X-ray and possibly some other tests may be required if clinically necessary.

To prepare for the immigration medical examination:

14. If you are mildly unwell or on a short course of antibiotics, wait until you are better before having your immigration medical examination.

15. Do not have alcohol or high fat meals 48 hours before your blood tests.

16. You have the right to bring a person to support you (i.e. family member, interpreter) for your medical examination

All applicants should bring the following:

17. The certificate with the relevant parts of sections A to J completed with your name at the top of each page where indicated.

18. Valid passport or national identity document for identification.

19. Three recent passport photographs. These must be no more than six months old.

a. A list of all your medications (including drug name and dosage).
b. Your immunisation record – if this is not supplied at the medical it will need to be before you are signed off by the BFSAI SMO.
c. All your medical notes and reports, blood test results, X-rays, scans & anything else that is relevant to your health if not held by your own GP.

d. Your glasses (spectacles) or contact lenses if you use them.

Female Applicants should note:

20. Do not have your immigration medical examination during your period (menstruation) because blood may affect the results. Wait until your period is finished before you have your immigration medical examination.

Applicants with children should note:

21. All children including babies must have an immigration medical examination.

22. Children age 11 years or younger DO NOT need a chest X-ray unless the physician declares it is necessary or one is requested by the MOD.

23. Children under 16 years of age DO NOT need a blood test unless the physician declares it is necessary or one is requested by the MOD.

After the examination, the following will occur:

24. Your doctor has to wait for all of your test results to complete the form.

25. Your application form is complete only when all the test results and specialist reports have been completed and attached and the doctor has completed all sections of the form.

26. You must submit your completed immigration medical certificates, including all blood test formal reports, and x-rays (chest x-ray certificate) and any other tests, within three months of the date the completed application form.

27. Your application will be assessed by the BFSAI Senior Medical Officer.

28. You may be required to get further specialist reports or tests. You are responsible for paying for these.

29. Your medical information may be retained by the Senior Medical Officer for use when assessing your health in the future or for audit reasons.

30. The BFSAI Senior Medical Officer will complete Section J and return to the contract manager in charge of your recruitment.

31. Once completed, please return this form to your prospective employer

32. If you have questions about completing the form, please contact the BFSAI Regional Medical Centre on +500 76334

BFSAI Full Medical Certificate

Section A	**Personal Details**

Question A1 must be completed by the examining doctor.

All other questions in this section must be completed by the applicant before the examination.

Please use a black pen and write clearly in English using CAPITAL LETTERS. Illegible forms will be returned for clarification. Tick or fill in all boxes.

Attach one recent passport-size colour photograph of yourself in the space provided. The photograph must be no more than six months old. Write your full name on the back of the photograph.

Photograph

A1	Examining physician certify identity by placing signature and date across photograph without obscuring the likeness of the person.				
	Valid Photographic ID		Yes		No
A2	Applicant Name as shown in passport				
	Family/ Last Name				
	Given/ First Name				
A3	Other names you are known by				
A4	Full Home Address				
	Telephone (Daytime)				
	Email				
A5	Gender	Male	Female	Prefer not to say	
A6	Date of Birth	*(DD/MM/YYYY)*			

A7	Country of Birth	
A8	Country of Citizenship	
A9	Number of Children	

A10 List all the countries you have lived, studied or worked in for three months in the past 5 years:

A11 What is your intended work activity in BFSAI?

Section B	**Medical History**

Applicant:

- The examining physician will complete this medical history section with your assistance.
- You (the applicant) must NOT complete this section.
- If the form is for a child under 16 years of age, the examining physician (or a delegated staff member such as a nurse) will complete the medical history section with the assistance of a parent or guardian.
- If you answer 'Yes' to any question, please give details and give the physician any reports, tests or other information.

Have you had or do you have any:

B1	Prolonged or repeated hospital admission and/ or surgery?	YES	NO	*If yes, please give details*
B2	Heart or Lung condition?	YES	NO	*If yes, please give details*
B3	Kidney/ Bladder condition?	YES	NO	*If yes, please give details*
B4	Diabetes?	YES	NO	*If yes, please give details*
B5	Neurological condition, hearing or vision problems?	YES	NO	*If yes, please give details*
B6	Physical, intellectual or development condition?	YES	NO	*If yes, please give details*
B7	Psychiatric (mental) problems or addiction?	YES	NO	*If yes, please give details*
B8	Hepatitis B, Hepatitis C or positive HIV tests?	YES	NO	*If yes, please give details*
B9	Tuberculosis (TB), treatment for TB, and/or household and/or occupational contact with someone with TB?	YES	NO	*If yes, please give details*
B10	Muscle, bone, skin, hereditary or autoimmune condition?	YES	NO	*If yes, please give details*
B11	Cancer, malignancy or organ transplant? When?	YES	NO	*If yes, please give details*
B12	Government assistance for medical or health disability reasons?	YES	NO	*If yes, please give details*

B13	Any treatment or therapy?	YES	NO	*If yes, please give details*
B14	Do you smoke or have you ever smoked?	YES	NO	*If yes, please give details*
B15	Do you consume alcohol?	YES	NO	*If yes, please give details (units per week)*
B16	Are you pregnant?	YES	NO	*If yes, please give details*

B17 List all medications and doses (Excluding contraceptive)

Drug Name	Dose	Quantity	Frequency

B18 Vaccination Status

Vaccine	Date given (if given)	Date Boosters given
Diphtheria, Tetanus, Pertussis		
Polio		
Hib		
Hepatitis B		
Hepatitis A		
Measles, Mumps, Rubella		
Meningitis C		
Typhoid		
Yellow Fever		
BCG		

B19 Family history: Please complete the table below detailing relationship, age and state of health of your parents, brothers and sisters. If they are deceased, please specify the age of death and

Relationship (father, brother)	Age	State of Health (If not good, state reason)	Cause of Death if deceased (Provide full details)	Age at death

Section C	**Declaration of Person Having the Medical Examination**

This declaration must be signed and dated by the person being examined in the presence of the examining physician. A parent or guardian must sign on behalf of a child under 16 years of age. Please read carefully before signing.

I understand the notes and questions in Section A and B of this certificate and I declare the information given about me is true, correct, and complete.

I understand that this declaration also applies to the laboratory test section.

I declare that I will inform Falkland Islands Immigration of any relevant fact or any change or circumstance that may affect the decision on my application due to my health circumstances.

I authorise BFSAI Senior Medical Officer to make any enquiries deemed necessary in respect of the information provided on this certificate and to share this information with other Government agencies (including overseas agencies) to the extent necessary to make decisions about my immigration status.

I undertake to pay the fees for this medical examination including laboratory tests and I also agree that I or my child will undergo, at my expense, any further medical examination(s) that may be required in respect of the immigration application.

I agree that the examining physician, and the laboratory that complete this certificate, may release to the Senior Medical Officer any information acquired with regard to the health of me or my child.

I understand that if I make any false statements or provide any false or misleading information, or have changed or altered this form in any material way after it has been signed, my application may be declined and I may lose any right of appeal of the decision to decline the application. I may become liable for deportation. I may also be committing an offence and I may be imprisoned.

Signature of person being examined		Date	
Of parent/ guardian (if applicable)			
Full name of parent/ guardian			
Relationship to applicant			

Declaration of Person Assisting
I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

Signature of person assisting		Date	
Full name of person assisting			

Declaration of examining Physician			
Signature of examining physician		Date	
Full name of examining physician			

Section D	**Physical Examination**

This section must be completed by the examining physician. Answer all questions.

Please add additional sheets of paper if you need more room. Sign, date and stamp each piece of paper.

Where abnormalities are indicated, please provide all the relevant details in the space provided and attach any existing specialist reports. If you do not have enough space, attach a separate sheet. All attached sheets must be initialled by the examining physician.

Was a chaperone present during the examination?	YES (Give details)	NO	DECLINED
Was an interpreter present during the examination?	YES (Give details)	NO	DECLINED

If yes, provide name and relationship to the person being examined

D1	Date of Examination	*(DD/MM/YYYY)*		
D2	Height (in Metres)		Weight (in KGs)	
	Body Mass Index (Kg/M^2)			
D3	Pulse Rate			
	Pulse Rhythm	NORMAL	ABNORMAL	*If abnormal, please give details*
D4	Blood Pressure	SYSTOLIC	DIASTOLIC	
D5	Heart Sounds	NORMAL	ABNORMAL	*If abnormal, please give details*
D6	Peripheral Pulses	NORMAL	ABNORMAL	*If abnormal, please give details*
D7	Uncorrected Visual Acuity	LEFT	RIGHT	
	Corrected Visual Acuity	LEFT	RIGHT	
D8	General Appearance			
D9	Cardiovascular System	NORMAL	ABNORMAL	*If abnormal, please give details*

D10	Respiratory System	NORMAL	ABNORMAL	*If abnormal, please give details*
D11	Ear, Nose and Throat	NORMAL	ABNORMAL	*If abnormal, please give details*
D12	Abdominal and Genitourinary System	NORMAL	ABNORMAL	*If abnormal, please give details*
D13	Neurological System	NORMAL	ABNORMAL	*If abnormal, please give details*
D14	Hearing	NORMAL	ABNORMAL	*If abnormal, please give details*
D15	Eye/ Fundal/ Colour Chart	NORMAL	ABNORMAL	*If abnormal, please give details*
D16	Psychiatric status	NORMAL	ABNORMAL	*If abnormal, please give details*
D17	Musculoskeletal System	NORMAL	ABNORMAL	*If abnormal, please give details*
D18	Skin and Lymph Nodes (including cervical lymph nodes in children under 15 years of age)	NORMAL	ABNORMAL	*If abnormal, please give details*
D19	Evidence of Drug Taking	YES	NO	*If yes, please give details*
D20	Breast Examination if clinically indicated from history.	NORMAL	ABNORMAL	*If abnormal, please give details*

D21	In your opinion, is the applicant able to live independently without significant support and perform activities of daily living without assistance?

YES	NO	*If yes, please give details*

Next Steps – Check List

Examining Physician:		Arrange urinalysis for all applicants five years of age or over
		Complete Laboratory Referral Form and detach for applicant to take when giving blood sample
		Consider noting any conditions which may be relevant to the radiologist when examining the x-ray. Refer to question D1 on the x-ray certificate.
Applicant:		Arrange urinalysis for all applicants five years of age or over

Section E Urinalysis and Blood Tests

This section must be completed by the examining physician on receipt of laboratory test results and urinalysis. The examining physician must sign and attach all test results.

Urinalysis

- May be completed via dipstick (by examining physician) or via laboratory. Where dipstick results return abnormalities attach full laboratory urinalysis.
- Required for all persons (except children under five years of age).
- Children under five years of age should have urinalysis if clinically indicated, for example, a history of kidney disease or recent tonsillitis.
- Females must not undergo urinalysis during their period (menstruation).
- Repeat/follow up laboratory urinalysis if positive blood pigment: red cells and/or test positive for protein.

E1	Urinalysis Results	Pregnant? (Female applicants only)	YES	NO

Date of Test/ Retest	Protein	Glucose	Blood

DATE		DIPSTICK		LABORATORY	
DATE (IF RETESTED)		DIPSTICK		LABORATORY	

Blood Tests

E2 Standard (compulsory) blood tests for all applicants aged 16 years of age and over.

Date	

HbA-1C	NORMAL	ABNORMAL	*Give Details*
Renal function test (to include serum urea, Creatinine and eGFR)	NORMAL	ABNORMAL	*Give Details*
Hepatitis B Surface Antigen (Hep B aAg)	NEGATIVE	POSITIVE*	*Give Details*
	**Request hepatitis B antigen, alphafetoprotein and liver function tests*		
Hepatitis C Serology	NEGATIVE	POSITIVE*	*Give Details*
	**Request HCVRNA*		
HIV	NEGATIVE	POSITIVE	*Give Details*
	**Request with Western Blot or local equivalent for confirming HIV*		
Treponemal Serology	NORMAL	ABNORMAL	*Give Details*
Full Blood Count	NORMAL	ABNORMAL	*Give Details*

Please attach results of ALL laboratory tests	

Section F	**Examining Doctor's Summary of Findings**

This section is COMPULSORY. Please provide your comments on the history and health of this applicant, especially any areas where you consider follow-up is required. Please note any further tests or investigations that you would recommend.

Recommendation

Please consider the information provided about this applicant and refer to the BFSAI Senior Medical Officer if you have any queries regarding your recommendation. Based on the history, examination, the laboratory tests and the X-ray (if provided), you must consider whether:

- There are any significant findings *(If YES, please expand/explain. Use a separate sheet or paper if required)*
- There are any abnormal findings
- There are no significant or abnormal findings

	No significant or abnormal findings.
	Abnormal findings (not significant).
	Significant findings (If YES, please expand/ explain. Use a separate sheet of paper if required.

Section G	**Examining Doctor's Declaration**

This declaration must be signed and dated by the examining physician responsible for this examination and must be signed after the examining doctor has sighted and considered all medical test results. Please read carefully before signing. Please write name and other details below.

I certify that this person has been examined by me or staff under my supervision and their identification presented has been examined to the best of my knowledge.

I certify that all tests, investigations and reports I have considered are signed by me and securely attached.

Signature of Examining Doctor		Date	
Examining Doctor's Full Name			
Place of Examination (City/ State and Country			
Postal Address			
Daytime Telephone Number			
Email Address			
Would you like the BFSAI SMO to contact you about this information?		YES	NO

Issuing Authority Stamp

GMC Number or Equivalent professional body identifying number:	

Section H	Confirmation of Identity and Declaration prior to blood testing

Applicant

- Complete H1 to H7 before your examination.
- Take a valid form of photographic identification with you to your appointment.
- Present this form when having blood taken for testing.

Person Taking Blood Valid photographic identification sighted? (i.e. Passport)		Yes

Applicant Details

H1	Passport Number						
H2	Applicant Name as shown in passport						
	Family/ Last Name						
	Given/ First Name						
H3	Other names you are known by						
H4	Gender	Male	Female	Prefer not to say	H5	Date of Birth	*(DD/MM/YYYY)*
H6	Country of Birth						
H7	Country of Citizenship						

Applicant's Declaration

Signature of person being examined		Date	

Declaration of Person Assisting
I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

Signature of person assisting		Date	
Full name of person assisting			

Declaration of Person Taking Blood

Signature of person taking blood		Date	
Full name of person taking blood			

Section I	**Declaration from BFSAI Senior Medical Officer**

This section must only be completed by the BFSAI Senior Medical Officer who should tick the appropriate statement below:

Full Name	

Is certified medically fit for:	
a) Long term work in BFSAI subject to continued medical fitness in accordance with terms set out in the contract of employment.	
b) Not fit	

In the case of b) please provide a report to the Principal Immigration Officer

Signature of Senior Medical Officer		Date	

Issuing Authority Stamp