TURKS AND CAICOS ISLANDS
MIGRANTS' HEALTH EVALUATION FORM

PART A
(TO BE COMPLETED BY PHYSICIAN AND APPLICANT)

________________________ ________________________ ________________________
First Name Middle Name Last Name

____________ ______________________ ______________________ __________________
Date of Birth Nationality Country of Residence Passport Number

Sex: Male Female Marital Status: Single Married Divorced

Residency for the purpose of (circle): 1. Private sector Employment, 2. Public Sector Employment, 3. Study, 4. Residency without the right to work, 5. Other ______________________

Dependants: Yes No If yes please list ages ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

1. Have you ever had or currently have YES NO

(a) High blood pressure or heart trouble?

(b) Diabetes?

(c) Kidney or urinary bladder problem?

(d) Disease of the joints?

(e) Asthma or hay fever?

(f) Stroke or disease of the brain?

(g) Fits or convulsions?

(h) Nervous or mental problems?

(i) Rheumatic fever?

(j) Eye problems?

(k) Frequent or prolonged indigestion?

(l) Any form of cancer?

(m) Any major surgery?

(n) Prolonged contact with anyone with tuberculosis?

(o) Lung tuberculosis?

(p) Leprosy?

(q) Malaria?

(r) Dysentery or any other tropical illness?

 Examining Physician's Signature:____________________________

MIGRANT'S HEALTH STATUS EVALUATION FORM

Application No. __________ Name___________________________ Passport Number_______________

	YES	NO
(s) Sexually transmitted disease?		
(t) Any physical defect?		
(u) Any illness or injury not mentioned above?		
(v) Family history of diabetes, high blood pressure, tuberculosis, mental illness, fits?		
(w) Prescribed medication for any of the conditions mentioned above		
2. Have you had any acute respiratory tract infection within the last 3 months?		
3. Do you drink alcohol?		
4. Do you use illicit drugs?		
5. Do you Smoke?		
6. Have you ever applied for or received disability benefits?		
7. Do any member of your family or dependants have any medical problems?		

If you answered yes to any of questions 1, 2, 3, 4 or 5 please give details below or on separate sheet provided on page 5.

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8. Are you now in good health? Yes No If no, give details below

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9. Are you now pregnant? Yes No Not applicable If yes, how many months _________

PART B

PHYSICAL EXAMINATION

(TO BE COMPLETED BY EXAMINING PHYSICIAN)

1. Is the Applicant personally known to you? Yes No
   If no, did you check his / her ID? Yes No

2. Height ________ft ______inch Weight _______lbs (in under clothes) Waist _______inches
   Chest Measurement: On inspiration ______inch On expiration _______inch
3. Blood Pressure: lying down __________ sitting __________
4. Pulse rate: at rest_________ after 1 minute of brisk activity _________

 Examining Physician's Signature:____________________________

MIGRANT'S HEALTH STATUS EVALUATION FORM

Application No. ___________ Name_________________________ Passport Number_____________

5. Please tick 'yes' if you find abnormality in any of the organ systems below or tick 'no' if they are free of disease or abnormality.

	Yes	No		Yes	No
(a) Skin			(g) Cardiovascular system		
(b) Throat & mouth			(h) Respiratory system		
(c) Eyes			(i) Musculo-skeletal system		
(d) Ears			(j) Nervous system		
(e) Nose			(k) Genito-urinary system		
(f) Gastrointestinal			(l) Mental Status		

If you ticked 'yes' to any of the questions above please provide details in space below or on blank page provided.

PART C

SCREENING AND DIAGNOSTIC EVALUATION

(TO BE COMPLETED BY EXAMINING PHYSICIAN)

1. Chest Radiograph: X-ray number ________ Date performed________ Result: Normal / Abnormal (circle)

   If abnormal, please state abnormality ____

   (Please note that chest x-ray MUST NOT be more than 6 months old for new applications and not more than 2 years old for renewal applications. Tuberculin test can be performed on pregnant women in lieu of chest x-ray. Chest x-ray is not required for persons under 15 unless clinically indicated or tuberculin test strongly positive).

2. Electrocardiogram: Date performed___________ Results: Normal / Abnormal (circle)

   If abnormal, state abnormality ____

   (Please note ECG is only required for persons over the age of 40 years and or with significant cardiovascular risk)

3. Urinanalysis: Date performed _______ Albumin ___ Glucose __ Blood _____ other positives ___________

4. Blood Tests:

	Date performed	Result
a. VDRL:	______________	____________________
b. HIV Screen:	______________	____________________
c. Hepatitis B:	______________	____________________

(Please note that proof of hepatitis B immunization and a negative Hepatitis B test is required by ALL workers in the health and hospitality industries. Children under the age of 15 are not required to do serological test for HIV, syphilis or Hep B unless it is clinically indicated)

Examining Physician's Signature:____________________________

MIGRANT'S HEALTH STATUS EVALUATION FORM

Application No. ______________ Name______________________ Passport Number____________

5. Other Tests:

	Test	Date performed	Result
a.	Mantoux Test	_________________	< 10mm or >10mm

(Please note persons with Mantoux test result >10mm must have a chest X-Ray)

	Test	Date performed	Result
b.	Drug Screen:		
	i. Marijuana	_________________	_____________________________
	ii. Cocaine	_________________	_____________________________
	iii. Heroin	_________________	_____________________________

Please note that children under the age of 15 are not required to do drug screen unless indicated from history or clinical exam.
Drug screen is only mandatory for persons being employed by the Turks and Caicos Islands Government.

Please attach laboratory and other reports to this application for submission to the NHIB

6. Vaccinations
Proof of vaccination against Measles, Mumps, Rubela, Polio, Tetanus, Diphtheria, and Pertussis are required

Name of Examining Physician:____

(IN BLOCK CAPITALS)

Qualifications:_________________________________ Medical Registration / License Number:_______________

Address of registering body / Medical Council: ____

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Examining Physician's Contact Information: Email _____________________________ Phone________________

Signature & Stamp of Examining Physician:___________________________________ Date: _________________

Consent for release of information

I ________________________________, (the applicant / the legal Guardian) hereby acknowledge that this medical evaluation is being performed for the purpose of determining my eligibility for residency in the Turks and Caicos Islands and as such I consent to the review this medical report by duly authorized officers within the Ministry of Health and any other relevant government authorities in the Turks and Caicos Islands.

Signature of Applicant/Legal Guardian:____ Date: ________________

Employer's Name: ____

Employer's Email:______________________________ Employer's Phone:___________________________________

MIGRANT'S HEALTH STATUS EVALUATION FORM

Application No. _________ Name_____________________ Passport Number____________

FOR OFFICIAL USE ONLY BY AUTHORIZED EXAMINING PHYSICIAN

Authorized Examining Physician's Signature ____

FOR OFFICIAL USE ONLY BY CERTIFYING HEALTH OFFICER

Certifying Health Officer's Signature____

Examining Physician's Signature:____________________________