DEPARTMENT OF IMMIGRATION
Government of the Virgin Islands
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Phone: (284) 468-4700

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.

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
(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, ts, any kind of tuberculosis, diabetes or raised blood pressure?	☐	☐
(n) Any illness or injury not mentioned above?	☐	☐
(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

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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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