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.

_____

_____

_____

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

_____

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

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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 <u>MUST NOT</u> 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)

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: _____

_____

_____

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:_____

 Examining Physician's Signature:_____

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_____