

IMMIGRATION REGULATIONS, 1974

MEDICAL CERTIFICATE

(For persons who wish to remain in Trinidad and Tobago for periods exceeding one year)

DECLARATION BY APPLICANT

(which must be made in the presence of the Examining Medical Officer)

Name
(Full name in block capitals)

Address

1. Have you or any member of your family included in this application ever had any serious illness or surgical operations?
If so list them
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2. Have you or has any member of your family ever been under treatment for tuberculosis?
If so with what results? (report from Thoracic Medical Officer to be supplied; Chest X-ray of applicant to be produced)

3. Have you ever suffered from Malaria?
(Evidence to be produced, bacteriological, etc.)
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When and where was your last attack?
Where did you contract the disease?

4. Have you or has any member of your family ever been under treatment for Leprosy?
If so with what results?
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(Evidence to be produced, bacteriological, etc.)
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5. Have you or has any member of your family ever suffered from mental disease, fits epilepsy, or been treated for these or similar diseases or other disorder?

I hereby certify that the information supplied by me to the Medical Examiner is correct in every particular.

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Signature of Applicant

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PHYSICAL EXAMINATION OF APPLICANT

(To be completed by Examining Medical Officer after Form 40 has been presented)

Name of Applicant

Height Weight

Eye Abnormalities: Hearing (conversation voice):
Right Left Right Left

Head and Neck Ear Drums

Spine Skin

Lungs Chest X-ray

Heart Pulse Blood Pressure

Abdomen Hernia

Repeat Blood Pressure if Abnormal

Genito-Urinary

Neurological

Is Applicant Pregnant?

Urinalysis

Remarks

Qualifications

Address

Date
Signature of Examining Medical Officer

I certify that I have this day examined the above-named person and that the results are as set forth, and I certify that in my opinion, subject to any special observations under "Remarks," he/she is in good health and of sound constitution, and not suffering from any infectious, mental or bodily defects which prevent him/her from earning his/her own living.

Remarks
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.

Date
*Signature and Qualifications
Medical Officer and Practitioner*

Address
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This form must be filled in by/for every applicant over 16 years old and by parents or guardians on behalf of applicants less than 16 years old.