



# WORC

Workforce Opportunities & Residency Cayman  
Cayman Islands Government

## MEDICAL EXAMINATIONS FORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

PAGE 1 OF 4

1. The Medical examinations are valid for one (1) year.
2. Chest Xrays are valid for three (3) years.
3. Medical practitioners are advised to perform any tests that might be desirable depending on the disease prevalence in the respective countries.
4. The Medical Examinations Form must be signed, stamped, or sealed and retained by the medical examiner.
5. WORC reserves the right to require additional medical examinations at any time.

### Part 1: QUESTIONNAIRE (to be completed by the applicant)

First Name								Last Name			
Maiden Name								Nationality			
Passport No.								Country of Birth			
Date of Birth	<input type="text"/>	Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male							
Telephone	<input type="text"/>				<input type="text"/>			<input type="text"/>			
Physical Address	<input type="text"/>	<input type="text"/>				<input type="text"/>	<input type="text"/>				
	Apt#	Bldg Name					House#	Street Name			
Mailing Address	<input type="text"/>				<input type="text"/>			<input type="text"/>			
	District				Neighbourhood						
E-Mail Address	<input type="text"/>				Employment Status			<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed		

**Note:** As a data controller, WORC complies with the Data Protection Act (2021 Revision). The personal data provided in this form will be used to determine any application for the examined individual to live and work in the Cayman Islands. We may verify the information that has been provided, including contacting you directly if we have any questions about this medical examination. Visit [www.worc.ky](http://www.worc.ky) for our full privacy statement.



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Have you ever had or currently have (Choose all applicable)\*

	YES	NO		YES	NO
a. Nervous or mental trouble	<input type="checkbox"/>	<input type="checkbox"/>	g. Eye trouble?	<input type="checkbox"/>	<input type="checkbox"/>
b. Fits or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	h. Any serious operation?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart trouble or raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	i. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
d. Lung tuberculosis, Asthma or hay fever?	<input type="checkbox"/>	<input type="checkbox"/>	j. Any illness or injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
e. Cancer or other malignancy	<input type="checkbox"/>	<input type="checkbox"/>	k. Family history of mental trouble, suicide, fits, any kind of tuberculosis, diabetes or raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
f. A sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>			

\*If you have answered **Yes** to any of these, please explain

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Do you consume alcohol?

<input type="checkbox"/>	<input type="checkbox"/>
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\*If Yes, how many alcoholic drinks do you typically consume in 1 week

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YES    NO

Do you take habit-forming drugs, including opiates, benzodiazepines, and prescription medications?

<input type="checkbox"/>	<input type="checkbox"/>
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YES    NO

\*If Yes, please explain

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Have you ever applied for or received disability benefits?

<input type="checkbox"/>	<input type="checkbox"/>
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YES    NO

\*If Yes, please explain

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Are you now in good health?

<input type="checkbox"/>	<input type="checkbox"/>
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YES    NO

\*If No, please explain

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\_\_\_\_\_

Are you now pregnant?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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YES    NO    NOT APPLICABLE

\*If Yes, how many months

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\_\_\_\_\_

Applicant printed name

Date

Signature

<input type="checkbox"/>					
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\_\_\_\_\_

Medical Examiner printed name

Date

Signature

<input type="checkbox"/>					
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### Part 2: MEDICAL EXAMINATION (to be completed by Medical Examiner)

Is the Examinee personally known to you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If No, did you check ID?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Height (ft/in) <input type="text"/>	Weight (lbs. in under clothes) <input type="text"/>	Body mass index <input type="text"/>
Date and report of last E.C.G. if any <input type="text"/>		
Blood pressure <input type="text"/>	Pulse rate <input type="text"/>	

Are the following free from any pathological condition or abnormality (Choose all applicable)\*

a. Skin	YES <input type="checkbox"/>	NO <input type="checkbox"/>	e. Nose	YES <input type="checkbox"/>	NO <input type="checkbox"/>	i. Locomotor System	YES <input type="checkbox"/>	NO <input type="checkbox"/>
b. Throat & Mouth	<input type="checkbox"/>	<input type="checkbox"/>	f. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	j. Nervous System	<input type="checkbox"/>	<input type="checkbox"/>
c. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	g. Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	k. Genito-Urinary System	<input type="checkbox"/>	<input type="checkbox"/>
d. Ears	<input type="checkbox"/>	<input type="checkbox"/>	h. Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>			

\*If No to any of the above questions, provide details

Is the applicant taking any medications at present or within the last six (6) months?

<input type="checkbox"/>	<input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	*If Yes, please explain <input type="text"/>
				<input type="text"/>

Give details of any operations

Medical conditions

a. <input type="text"/>	b. <input type="text"/>
c. <input type="text"/>	d. <input type="text"/>

Medical Examiner printed name

Date of Examination

Signature



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PAGE 4 OF 4

### Part 3: XRAY AND LABORATORY INVESTIGATIONS (to be completed by Medical Examiner)

Hospital Xray No	<input type="text"/>	Date	<input type="text"/>	Results	<input type="text"/>	
Urine:	Date	<input type="text"/>	Albumin	<input type="text"/>	Sugar	<input type="text"/>
Blood Tests:	SYPHILIS	Date	<input type="text"/>	Results	<input type="text"/>	
	HIV SCREEN	Date	<input type="text"/>	Results	<input type="text"/>	

#### Medical Examiner

First Name  Last Name

Medical Registration Number

Qualifications

Address of Registering Body

Mailing Address     
P.O. Box  Postal Code  Post Office

E-Mail Address

Date of Examination	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Signature	<input type="text"/>
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**Note:** A medical examination before arrival in the Cayman Islands may only be completed by a practitioner fully registered as a medical doctor by the medical councils of either the United Kingdom, United States, Canada, or the Cayman Islands. If a medical examination cannot be undertaken by a practitioner who is registered in one of these countries WORC will offer a temporary condition to allow the person to enter, however, they cannot work until a medical examination has been completed in the Cayman Islands, by a medical doctor registered in the Cayman Islands, and the medical declaration cover letter has been submitted.