WORC
Workforce Opportunities & Residency Cayman
Cayman Islands Government

MEDICAL EXAMINATIONS FORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

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 (D D M M Y Y Y Y) | Sex ☐ Female ☐ Male

Telephone: Cell | Home | Work

Physical Address: Apt# | Bldg Name | House# | Street Name

District | Neighbourhood

Mailing Address: P.O. Box | Postal Code | Post Office

E-Mail Address | Employment Status ☐ Employed ☐ 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 for our full privacy statement.

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

	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. Cancer or other malignancy	☐	☐
f. A sexually transmitted disease?	☐	☐
g. Eye trouble?	☐	☐
h Any serious operation?	☐	☐
i. Diabetes?	☐	☐
j. Any illness or injury not mentioned above?	☐	☐
k. Family history of mental trouble, suicide, fits, any kind of tuberculosis, diabetes or raised blood pressure?	☐	☐

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

_____

Do you consume alcohol? ☐ YES ☐ NO

*If Yes, how many alcoholic drinks do you typically consume in 1 week _____

Do you take habit-forming drugs, including opiates, benzodiazepines, and prescription medications? ☐ YES ☐ NO

*If Yes, please explain _____

_____

Have you ever applied for or received disability benefits? ☐ YES ☐ NO

*If Yes, please explain _____

_____

Are you now in good health? ☐ YES ☐ NO

*If No, please explain _____

Are you now pregnant? ☐ YES ☐ NO ☐ NOT APPLICABLE

*If Yes, how many months _____

_____

Applicant printed name _____

Date ☐☐ ☐☐ ☐☐

Signature _____

Medical Examiner printed name _____

Date ☐☐ ☐☐ ☐☐

Signature _____

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Part 2: MEDICAL EXAMINATION (to be completed by Medical Examiner)

Is the Examinee personally known to you? YES ☐ NO ☐ If No, did you check ID? YES ☐ NO ☐

Height (ft/in) ☐ Weight (lbs. in under clothes) ☐ Body mass index ☐

Date and report of last E.C.G. if any ☐

Blood pressure ☐ Pulse rate ☐

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

	YES	NO		YES	NO		YES	NO
a. Skin	☐	☐	e. Nose	☐	☐	i. Locomotor System	☐	☐
b. Throat & Mouth	☐	☐	f. Abdomen	☐	☐	j. Nervous System	☐	☐
c. Eyes	☐	☐	g. Cardiovascular System	☐	☐	k. Genito-Urinary System	☐	☐
d. Ears	☐	☐	h. Respiratory System	☐	☐			

*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? YES ☐ NO ☐ *If Yes, please explain ☐

☐

Give details of any operations ☐

☐

Medical conditions a. ☐ b. ☐

c. ☐ d. ☐

Medical Examiner printed name ☐

Date of Examination ☐☐ ☐☐ ☐☐

Signature ☐

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

Hospital Xray No | Date | Results

Urine: Date | Albumin | Sugar

Blood Tests: SYPHILIS Date | Results

HIV SCREEN Date | Results

Medical Examiner

First Name

Medical Registration Number

Qualifications

Address of Registering Body

Mailing Address

P.O. Box | Postal Code | Post Office

E-Mail Address

Date of Examination ☐☐ ☐☐ ☐☐ Signature

Note: The prescribed Medical Declaration Cover Letter must be submitted with all applications, including Temporary Work Permits and Business Visitor's Permits. To meet this requirement, the applicant must take this Medical Examination Form to a registered medical doctor for examination and certification. After the examination, both the applicant and the medical doctor must complete the Medical Declaration Cover Letter to accompany the submission of the WORC application. If the application is approved, all Medical Examinations carried out outside of the Cayman Islands, United Kingdom, United States, or Canada will need to be redone upon arrival in the Cayman Islands and resubmitted within seven (7) days of arrival. In the case of a work permit application, note that employment cannot commence until the Medical Declaration Cover Letter has been resubmitted.