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 five (5) 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. Tuberculosis?	☐	☐
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 ☐

Peak flow rate ☐ 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 ____ 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 ____ ____ ____ ____ ____ ____ Signature ____

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.