



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	<input type="text"/>	Last Name	<input type="text"/>	
Maiden Name	<input type="text"/>	Nationality	<input type="text"/>	
Passport No.	<input type="text"/>	Country of Birth	<input type="text"/>	
Date of Birth	<input type="text"/> D D M M Y Y Y Y	Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male	
Telephone	<input type="text"/> Cell	<input type="text"/> Home	<input type="text"/> Work	
Physical Address	<input type="text"/> Apt#	<input type="text"/> Bldg Name	<input type="text"/> House#	<input type="text"/> Street Name
	<input type="text"/> District		<input type="text"/> Neighbourhood	
Mailing Address	<input type="text"/> P.O. Box	<input type="text"/> Postal Code	<input type="text"/> Post Office	
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 for our full privacy statement.



WORC

Workforce Opportunities & Residency Cayman
Cayman Islands Government

MEDICAL EXAMINATIONS FORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

PAGE 2 OF 4

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

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



WORC

Workforce Opportunities & Residency Cayman
Cayman Islands Government

MEDICAL EXAMINATIONS FORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

PAGE 3 OF 4

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"/>
--	------------------------------	-----------------------------	--------------------------	------------------------------	-----------------------------

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)*

	YES	NO		YES	NO		YES	NO
a. Skin	<input type="checkbox"/>	<input type="checkbox"/>	e. Nose	<input type="checkbox"/>	<input type="checkbox"/>	i. Locomotor System	<input type="checkbox"/>	<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?	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

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.



WORC

Workforce Opportunities & Residency Cayman
Cayman Islands Government

MEDICAL EXAMINATIONS FORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

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"/>	Signature	<input type="text"/>
---------------------	----------------------	----------------------	----------------------	----------------------	----------------------	-----------	----------------------

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.