TURKS AND CAICOS ISLANDS MIGRANTS' HEALTH EVALUATION FORM

PART A
(TO BE COMPLETED BY PHYSICIAN AND APPLICANT)

First Name	Middle Name	Last Name

Date of Birth	Nationality	Country of Residence	Passport Number

Telephone Number	Email Address	Employer (TCI)	Job Title (TCI)

Sex: Male Female **Marital Status**: Single Married Divorced

Dependents: Yes No If yes please list ages ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Residency for the purpose of (circle):

Belonger Status	Belonger Status by Spouse	Endorsement	Freelance Work Permit
Home Owners Permit	Naturalization	Passport	Permanent Residency Permit (PRC)
Residence Permit	Status Card	Study	Temporary Work Permit
TCIG Public Service	Work Permit		

1. Have you ever had or currently have: (circle)

a)	High blood pressure or heart trouble?	YES	NO
b)	Diabetes?	YES	NO
c)	Kidney or urinary bladder problem?	YES	NO
d)	Disease of the joints?	YES	NO
e)	Asthma or hay fever?	YES	NO
f)	Stroke or disease of the brain?	YES	NO
g)	Fits or convulsions?	YES	NO
h)	Nervous or mental problems?	YES	NO
i)	Rheumatic fever?	YES	NO
j)	Eye problems?	YES	NO
k)	Frequent or prolonged indigestion?	YES	NO

l) Any form of cancer? YES NO

m) Any major surgery? YES NO

n) Prolonged contact with anyone with tuberculosis? YES NO

o) Lung tuberculosis? YES NO

p) Leprosy? YES NO

q) Malaria? YES NO

r) Dysentery or any other tropical illness? YES NO

s) Sexually transmitted disease? YES NO

t) Any physical defect? YES NO

u) Any illness or injury not mentioned above? YES NO

v) Family history of diabetes, high blood pressure, tuberculosis, mental illness, fits. YES NO

w) Prescribed medication for any of the conditions mentioned above? YES NO

2. **Have you had any acute respiratory tract infection within the last 3 months?** YES NO

3. **Do you drink alcohol?** YES NO

4. **Do you use illicit drugs?** YES NO

5. **Do you Smoke?** YES NO

6. **Have you ever applied for or received disability benefits?** YES NO

7. **Does any member of your family or dependents have any medical problems?** YES NO

If you answered yes to any of questions 1, 2, 3, 4 or 5 please give details below or on separate sheet provided on page 5.

---

8. **Are you now in good health?** Yes No If no, give details below

---

9. **Are you now pregnant?** Yes No Not applicable

If yes, how many months _____

PART B PHYSICAL EXAMINATION
(TO BE COMPLETED BY EXAMINING PHYSICIAN)

1. **Is the Applicant personally known to you?** Yes No
2. **If no, did you check his / her ID?** Yes No
3. **Height** _____ft. _____inch **Weight** _____lbs. **Waist** _____inches
4. **Chest Measurement**: on inspiration _____inch on expiration _____inch
5. **Blood Pressure**: lying down _____ sitting _____
6. **Pulse rate**: at rest_____ after 1 minute of brisk activity _____
7. **Blood test results**: Fasting blood sugar (FBS) _____ mg/dL **or** Random blood sugar (RBS) _____ mg/dL

8. **Please circle 'yes' if you find abnormality in any of the organ systems below or circle 'no' if they are free of disease or abnormality.**

(a) Skin	Yes	No	(g) Cardiovascular system	Yes	No
(b) Throat & mouth	Yes	No	(h) Respiratory system	Yes	No
(c) Eyes	Yes	No	(i) Musculo-skeletal system	Yes	No
(d) Ears	Yes	No	(j) Nervous system	Yes	No
(e) Nose	Yes	No	(k) Genito-urinary system	Yes	No
(f) Gastrointestinal	Yes	No	(l) Mental Status	Yes	No

If you ticked 'yes' to any of the questions above please provide details in space below or on blank page provided.

PART C SCREENING AND DIAGNOSTIC EVALUATION
(TO BE COMPLETED BY EXAMINING PHYSICIAN)

1. **Chest Radiograph:** X-ray number _____ Date performed_____ Result (circle): Normal / Abnormal

If abnormal, please state abnormality _____

2. **Electrocardiogram:** Date performed_____ Results: Normal / Abnormal (circle)

If abnormal, state abnormality _____

(Please note ECG is only required for persons over the age of 40 years and or with significant cardiovascular risk)

3. **Urinalysis:** Date performed _____ Albumin _____ Glucose ____ Blood _____ other positives _____

4. **Blood Tests:** Date performed Result

a. VDRL: _____ _____

b. HIV Screen: _____ _____

c. Hepatitis B: _____ _____

5. **Tuberculosis Screen:**

TEST	DATE PERFORMED	RESULT	TB STATUS
Mantoux Test	_____	_____ mm (exact measurement)	☐ Positive ☐ Negative
QuantiFERON Gold	_____		☐ Positive ☐ Negative

Please complete either a Mantoux Test or a QuantiFERON Gold test. Persons with Mantoux test result >10mm must have a chest X-Ray

6. **Drug Screen:** Date performed Result

i. Marijuana _____ _____

ii. Cocaine _____ _____

iii. Heroin _____ _____

Drug screen is only mandatory for persons being employed by the Turks and Caicos Islands Government.

7. **Immunization:**

Proof of vaccination against Measles, Mumps, Rubella, Diphtheria, Tetanus, Pertussis and Polio are required.

Applicants should be fully vaccinated according to PAHO/WHO standards with at least 5 DPT, 5 Polio and 2 MMR vaccines. If an adult does not have a childhood vaccination card, they may receive vaccines formulated for adults and are considered fully vaccinated for migrant health purposes if they have received at least 3 DT, 2 MMR and 1 IPV vaccine. There should be at least 28 days between each vaccination day. The 3rd DT vaccine should be received 6 months or more after the 2nd. The MHU application will be conditional approved for 1 year after receiving 2 DT, 2 MMR, and 1 IPV vaccine with the condition that the client receives the 3rd DT after approval. Or submit IgG titers for measles, mumps, rubella, diphtheria, tetanus, pertussis and polio. IgG titers should be less than 6 months old, and the MHU application will be approved for 1 year only. Negative IgG titers will require vaccination.

Name of Examining Physician _____

Qualifications: _____ Medical Registration / License Number:_____

Address of registering body / Medical Council: _____

_____

Examining Physician's Contact Information: Email _____ Phone_____

Signature & Stamp of Examining Physician: _____ Date: _____

Applicant's consent for release of information

I _____, (the applicant / the legal Guardian) hereby acknowledge that this medical evaluation is being performed for the purpose of determining my eligibility for residency in the Turks and Caicos Islands and as such I consent to the review this medical report by duly authorized officers within the Ministry of Health and any other relevant government authorities in the Turks and Caicos Islands.

Signature of Applicant/Legal Guardian: _____ Date: _____

Employer's Name: _____

Employer's Email: _____ Employer's Phone: _____

SUBMISSION GUIDELINES

- Children 15 years and under are only required to submit this form, passport copy, vaccinations and urinalysis.
- Children 2 years and under are only required to submit this form, passport copy and vaccinations.
- Applicants of any age may be subject to additional testing if medically indicated.
- Any abnormal results should be investigated and treated.
- Evidence of treatments should be submitted along with the medical reports.
- All medical reports submitted must not be older than 6 months at the time of submission.
- Create an account and track the status of your application at https://healthcertificate.gov.tc/
- For more information, please contact the Migrant Health Unit at migranthealth@gov.tc

The following medical reports must be submitted along with the completed application form:

Medical Tests	Adults	Children (15 and under)
Chest X-Ray Report	✓	**x**
Electrocardiogram (ECG)	✓ 40 years +	**x**
Urinalysis	✓	✓ 2 years +
Blood Tests (HIV, Hep B, VDRL)	✓	**x**
Mantoux or QuantiFERON	✓	**x**
Drug Test	✓ TCIG employees only	**x**
Immunization (DPT, IPV, MMR)	✓	✓

FOR OFFICIAL USE ONLY BY AUTHORIZED EXAMINING PHYSICIAN

_____

_____

_____

_____

_____

_____

_____

_____

Authorized Examining Physician's Signature _____