

YOUR MEDICAL EXAMINATION

1. SCHEDULING YOUR APPOINTMENT

You must schedule your medical examination at least 10 days prior to the date of your visa interview. The date of your visa interview appears on your appointment letter. **Failure to complete your medical examination by the 10 days prior to your visa interview may result in delays with your visa application,** so you should be sure to make arrangements to take your exam at the earliest opportunity.

Below is the location of the medical facility authorized to perform examinations for immigrant visas.

Andrews Memorial Hospital
27 Hope Road
Kingston 10
(876) 926-7401-3

You must call ahead to schedule a specific appointment time.

2. WHAT TO BRING TO THE MEDICAL EXAMINATION

- Completed medical history form (on reverse)
- Any relevant medical reports
- Exam and vaccination fees
- Any immunization records showing prior vaccinations
- All medication containers and/or most recent prescriptions
- Your appointment letter
- Passport
- Four (4) passport size pictures
- Reading glasses (if used)
- Parent/guardian (for minor applicants)

***Please remove all necklaces and neck chains prior to the exam.

3. IMMUNIZATION

U.S. immigration law requires that all applicants be vaccinated for the following diseases:

Mumps, measles, rubella, polio, tetanus, diphtheria, pertussis, influenza type B, hepatitis B, varicella (chicken pox), pneumococcal, and influenza.

Depending upon your age, you may not need all of these vaccinations. Please present your immunization records to the physician at the time of the examination for the physician to determine which immunizations you may need. You may receive any needed vaccinations at the time of your examination. **Please note that immunization fees are not included in the cost of your examination. Please be prepared to pay for any additional vaccines that you may require.**

IMPORTANT
PLEASE READ BOTH SIDES OF THIS FORM CAREFULLY
PLEASE LEAVE THIS FORM AT THE DOCTOR'S OFFICE

APPLICANT'S MEDICAL HISTORY & PHYSICAL EXAMINATION

Name: (Last, First, M)			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Birth Date (mm-dd-yyyy):	Passport Number:	Date of Issue (mm-dd-yyyy):	Alien (Case) Number:	
Birth Place (City / Country):		Height:	Weight:	
Present Address:		Occupation:	Age:	
Local Phone Number:		Email Address:		

Past Medical History (indicate conditions requiring medication or other treatment after resettlement and give details in "Remarks")

NOTE: The following information is self-reported, has not been verified by a physician, and should not be medically definitive.

<table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 20px;">NO</td> <td style="text-align: center; width: 20px;">YES</td> <td style="width: 5px;"></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Illness or injury requiring hospitalization (including psychiatric)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Heart disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Hypertension</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>History of tobacco use Current use: ____ Yes ____ No</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Asthma</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Lung disease</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>History of stroke, with current impairment</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Seizure disorder (fits)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Major impairment in learning, self care, Intelligence, memory or communication</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Major mental disorder (including major depression, bipolar disorder, mental retardation, schizophrenia)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Current or past use of drugs (including ganja) not prescribed by a doctor</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Other substance related disorders (including alcohol addiction or abuse)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="width: 5px;"></td> <td>Have you ever taken action to end your life?</td> </tr> </table>	NO	YES			<input type="checkbox"/>	<input type="checkbox"/>		Illness or injury requiring hospitalization (including psychiatric)	<input type="checkbox"/>	<input type="checkbox"/>		Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		History of tobacco use Current use: ____ Yes ____ No	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Lung disease	<input type="checkbox"/>	<input type="checkbox"/>		History of stroke, with current impairment	<input type="checkbox"/>	<input type="checkbox"/>		Seizure disorder (fits)	<input type="checkbox"/>	<input type="checkbox"/>		Major impairment in learning, self care, Intelligence, memory or communication	<input type="checkbox"/>	<input type="checkbox"/>		Major mental disorder (including major depression, bipolar disorder, mental retardation, schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>		Current or past use of drugs (including ganja) not prescribed by a doctor	<input type="checkbox"/>	<input type="checkbox"/>		Other substance related disorders (including alcohol addiction or abuse)	<input type="checkbox"/>	<input type="checkbox"/>		Have you ever taken action to end your life?	<table style="width: 100%; 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GIVE DETAILS BELOW OF ANY CONDITIONS MENTIONED ABOVE:

I certify that the above information is true and that I have not withheld any major information regarding any medical history. I understand that if at any time it is proved that medical information has been withheld, I may be refused a visa. I also certify that I understand the purpose of the medical examination, and I authorize the required tests below to be completed. The information on this form refers to me.

Signed: _____ (Applicant) _____ (Date)

DO NOT WRITE BELOW THIS LINE

HIV & VDRL <input type="checkbox"/>	X-Ray <input type="checkbox"/>	Medical Examination <input type="checkbox"/>
Vision	Uncorrected L 20/ R 20/ BP	Pulse Resp.
	Corrected L 20/ R 20/	

Remarks: _____