DÉPARTMENT DE L'IMMIGRATION

Services de L'Immigration et de Passeport de Vanuatu
Autoroute Kumul, Tamarama Building
Tél: (678) 22 354 / (+678) 33125
Email: visqueries@vanuatu.gov.vu
Web: www.immigration.gov.vu
P.O.Box 9092, Port-Vila, Vanuatu

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MEDICAL REPORT

PART A: TO BE COMPLETED BY THE APLICANT BEFORE VISITING THE DOCTOR

1. Family Name:

2. Given Name:

3. Gender: ☐ Male ☐ Female **4.** Date of Birth: / /

5. How long do you intend to staying in Vanuatu?

6. Your Medical history	Have you ever had Please tick Yes or No		If yes . Provide details
a) An operation	☐	☐	
b) Been admitted to hospital?	☐	☐	
c) Tuberculosis?	☐	☐	
d) An abnormal x-ray?	☐	☐	
e) An infectious disease lasting	☐	☐	
f) Convulsion fits or epilepsy	☐	☐	
g) Anxiety depression or Nervous complaint	☐	☐	
h) High blood pressure?	☐	☐	
i) Heart trouble chest pain or Breathlessness	☐	☐	
j) Kidney or bladder disease or complaint?	☐	☐	
k) Any illness, injury or medical condition lasting More than 2 weeks or a recurring Condition not Mentioned above?	☐	☐	
l) Are taking any bills, medicine or having any other Medical treatment?	☐	☐	
m) Have you ever been addicted to a drug or taken Drugs illegally?	☐	☐	
n) Do you consume alcohol?	☐	☐	
o) Do you smoke or have you ever smoke Tobacco?	☐	☐	

APPLICANT DECLARATION-To be signed in the presence of the examination Doctor. I declare that the information I have provided on this form is correct.

Signature

Date / /

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PART B: EXAMINING DOCTOR'S FINDINGS

7. Height ____ Weight ____ **8.** Blood Pressure ____

	Please Tick Normal	Abnormal	Details
9. Cardiovascular system (record any evidence of heart Provide date and duration of Treatment and name. Strength and dosage of drugs used)	☐	☐	
10. Respiratory system (for current or previous TB Treatment and name, strength And dosage of drugs used)	☐	☐	
11. Nervous system	☐	☐	
12. Mental State	☐	☐	
13. Gastrointestinal system including Hermia orifices	☐	☐	
14. Locomotor system / Physical build / Mobility	☐	☐	
15. Skin and lymph nodes	☐	☐	
16. Endocrine system	☐	☐	
17. Ear / Nose / Throat / Mouth / Teeth	☐	☐	
18. Hearing Left	☐	☐	
Right	☐	☐	
19. Eyes	☐	☐	
20. VDRL test result— only in Clinically indicated	☐	☐	
21. Result of chest x-ray (it over 16 yrs)	☐	☐	
22. Hepatitis B antigen test result	☐	☐	
23. Human immunodeficiency virus result: please re-	☐	☐	

24. Urinalysis: Blood ____ Albumin ____ Sugar ____

DOCTOR'S CONCLUSIONS: Please consider the information you have provided about this applicant. Please consider if the applicant has the potential to be a health risk in Vanuatu or a financial burden to Vanuatu. Please tick the box:

No significant history or abnormal findings ☐ Significant his or abnormal findings present— attached details ☐

Doctor's Full Name: _____

Contact Phone: _____ Doctor's Signature _____ Date: _____