Medical Certificate AB3

The Government of Antigua and Barbuda

Application for Registration as a Citizen of Antigua and Barbuda

Citizenship by Investment Programme

For Official Use Only	
Reference Number	
Agents License Number	
Date Received	

Medical Certificate

This Medical Certificate Form is to be completed in English by a registered medical practitioner. Please supply additional details on a separate sheet if necessary. One form for each person (including children) is to be completed. Note that the medical practitioner must ask for evidence of identification (such as a passport or ID card).

Section A: Your Personal Details

A1. Surname or Family Name (as shown in passport)		**A2. First or Given Name(s)** (as shown in passport)	
A3. Place of birth	**A4. Country of birth**	**A5. Date of birth** D D M M Y Y Y Y	**A6. Gender** ☐ *Male* ☐ *Female*
A7. Principal Residential Address		**A8. Passport details** – Issuing Country and Passport Number	
A9. Name of main physician or doctor		**A10. Address of main physician or doctor**	

Section B: Statement of Health

The Medical Examiner is requested to ask the following questions or to review them if they have been answered previously. Give details (if necessary on an attached sheet) and dates if any of the questions below are answered with *Yes*.

B1. Past / Present Conditions: Have you had, or do you presently have, any of the following conditions:
Tuberculosis ☐ *Yes* ☐ *No*
Hepatitis (A, B, or C) ☐ *Yes* ☐ *No*
Typhoid ☐ *Yes* ☐ *No*
Any Other Communicable Disease ☐ *Yes* ☐ *No*
Any Other heart condition (including congenital defects) ☐ *Yes* ☐ *No*
Stroke ☐ *Yes* ☐ *No*

Any Immune Deficiency Disease ☐ *Yes* ☐ *No*
Cancer ☐ *Yes* ☐ *No*
AIDS / HIV ☐ *Yes* ☐ *No*

Please tick here ☐ *if there is more information at the end of this form or on an attached sheet*

Important: You must enclose original results of an HIV (AIDS) test showing clearly first name and surname. Note that the HIV test results must be not older than 3 months at the time of submission.

B2. Are you currently taking any prescribed medicine? ☐ *Yes* ☐ *No*
B3. Do you currently have any other serious health problems? (other than mentioned in B1) ☐ *Yes* ☐ *No*
B4. Have you been hospitalized in the last 5 years? ☐ *Yes* ☐ *No*
B5. Have you visited a doctor in the last three years for anything other than a routine check-up? ☐ *Yes* ☐ *No*
B6. For female applicants – Are you pregnant? **If Yes, what is the expected date of birth?** ☐ *Yes* ☐ *No*
B7. Are you dependent on alcohol or drugs (including narcotics)? ☐ *Yes* ☐ *No*
B8. Any further information which may be medically relevant

Please tick here ☐ *if there is more information at the end of this form or on an attached sheet*

Section C: Applicant Declaration, Date and Signature

- I declare the information I have provided on this form is correct.
- I understand that if I give false or misleading information, my application may be refused.
- I agree to the examining physician contacting my treating doctor to discuss and seek further information about any medical condition(s) that may relate to my health assessment as part of my application.

Place and date	**Signature of applicant**

In case of children below the age of 16, a parent or legal guardian must sign here	**Relationship to Child**

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Section D: Medical Examination

The Medical Examiner is required to examine the applicant generally and to answer the following questions. Give details and dates if any of the questions below are answered with a *Yes*, either in the space provided or on attached sheets

D1. Weight (in kg)	**D2. Height (in cm)**

D3. Skin – Are there any signs of skin disease?

☐ *Yes* ☐ *No*

D4. Respiratory system – Any sign of abnormalities, including nose and lungs?

☐ *Yes* ☐ *No*

D5. Cardiovascular system – Any signs of abnormalities, including pulse, blood pressure, heart murmurs?

☐ *Yes* ☐ *No*

D6. Digestive organs and abdomen – Any signs of abnormalities?

☐ *Yes* ☐ *No*

D7. Urogenital organs – Any signs of abnormalities?

☐ *Yes* ☐ *No*

D8. Nervous system and sense organs – Any signs of abnormalities?

☐ *Yes* ☐ *No*

D9. Musculoskeletal system – Any signs of abnormalities?

☐ *Yes* ☐ *No*

D10. Endocrine system – Any signs of abnormalities?

☐ *Yes* ☐ *No*

D11. Various – Any other signs of abnormalities?

☐ *Yes* ☐ *No*

D12. Contagious disease – Any sign of contagious diseases?

☐ *Yes* ☐ *No*

D13. Final evaluation

Please tick here ☐ *if there is more information at the end of this form or on an attached sheet*

Section E: Medical Examiner Details and Declaration

E1. Full name of medical examiner	
E2. Organization	
E3. Position	
E4. Address	
E5. Telephone number	**E6. Fax number**

I hereby confirm that I have identified, questioned and examined the applicant and have answered all questions to the best of my knowledge and in good faith.	
Place and date	**Signature of medical examiner**

Stamp of medical examiner (if applicable)

Attach Photograph here

35mm x 45mm

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