Falkland Islands Government

Name of Applicant

MEDICAL CERTIFICATE Revised v3.4 (September 2021)

Applicant's Note

The information in this section will help you complete this certificate. Please read the information in this section before you start to complete this certificate. This form must be completed by you, the applicant, or if you are under 16 by your parent/guardian. Your medical history and state of health must be confirmed by the examining physician by declaration at the end of section C. We reserve the right to contact your GP/Doctor to verify, seek confirmation of details within the form, and for further information where required.

If you have lived in or visited for 3 months or more a high risk country in the 5 years prior to your application - see Blood Tests v1.1 guidance notes, and Health Requirements guidance document (relating to chest X-ray) for lists of countries - you will be required to complete a Separate Blood Tests form - Blood Tests v1.1 and X-ray form - Chest X-ray Certificate.

This form is to be used by BRITISH passport holders *only* (GBR and BOTC)

Your responsibilities as the applicant

You must tell the truth. False statements on a medical certificate may result in your permit application being declined, any permit granted being cancelled, and if you are in the Falkland Islands, you being required to leave the country. It should also be noted that by not telling the truth on the form, or by giving misleading or incomplete medical details about a condition, you may become responsible for the cost of any medical treatment received in the Falkland Islands or overseas.
You must bring with you a valid passport to confirm identification.
You must also bring with you a list of all your medications (including drug name and dosage), and all medical notes, reports, and your immunisation records (if examining physician is not your GP).
You must submit your completed medical certificate within 3 months of the date of the examination.

You must share the Falkland Islands - CMO letter with your examining Doctor.

Once completed, please return this form to: medicals@kemh.gov.fk

Your application will be assessed by the Falkland Islands Government Chief Medical Officer and you will be informed of the result of the assessment in due course.

For more information:
If you have any questions about completing the form, please contact the King Edward VII Memorial Hospital on +500 28005 or e-mail **medicals@kemh.gov.fk**

Doctor's note

The Falkland Islands is an isolated British Overseas Territory with a population of less than 4000 people, located approx. 500 km east of South America and 1200km from Antarctica. Medical facilities are limited.

There are only five full-time GPs, one consultant general surgeon and one consultant anesthetist. The hospital's access to secondary care and emergency medical treatment is restricted - there is no CT or MRI scanner on the Islands.

If a patient becomes critically unwell, or unstable, they will be medically evacuated by aircraft - usually to Chile. Transfers usually take an average of 24 hours, this if often effected by limited aircraft availability or poor weather conditions on the Islands. Aeromedical evacuation facilities are limited to a maximum weight of 120kg - patients weighing in excess of this are unlikely to be able to be evacuated.

If your patient has a chronic or complex medical or mental health condition that requires regular monitoring, or has a condition that has the potential to deteriorate to such an extent that it will be unable to be managed within the islands medical services, please highlight this in the form.

Name of Applicant

Falkland Islands Government

Medical Certificate Revised

v3.4 (September 2021)

Section A

Question A1 must be completed by your GP/Doctor.
All other questions in Section A must be completed by the applicant, giving as much detail as possible. If the applicant is under 16 this section must be completed by their parent/legal guardian on their behalf.

Please note, that by not telling the truth on the form, or by giving misleading or incomplete medical details about a condition or problem, you may become responsible for the cost of any medical treatment received in the Falkland Islands or overseas.

Please complete clearly in black ink in English using **CAPITAL LETTERS**. Illegible or incomplete forms will be returned for clarification. Tick or complete all boxes.

A valid passport must be presented to the examining doctor to confirm identity of the applicant - Question A1

A1 Valid photographic identification? ☐ **YES** ☐ **NO**

Signed by examining Physician

A2 Applicant name as shown in passport:
Family / Last Name
Given / First Name

A3 Other names you are known by

A4 Full home address

Telephone (Daytime) E-mail

A5 Gender ☐ **Male** ☐ **Female**

A6 Date of Birth ____/____/____
Date Month Year

A7 Country of Birth

A8 Country of Citizenship

A9 Numbers of Children born to applicant

A10 List all countries you have visited, lived, studied or worked in for three (3) months or more in the last five (5) years

A11 Employer in the Falkland Islands (if applicable)

Name of Applicant

Section B Medical History and GP/Doctor's Declaration

Applicant:

- **Please complete in as much detail as possible. It is essential that you answer these questions honestly and with as much detail as possible. Failure to disclose important or relevant medical information may result in a permit being refused, or if already issued - revoked.**
- **If the applicant is under 16 this section must be completed by their parent/legal guardian on their behalf.**
- If you answer **'YES'** to any question below, please give details including any reports, tests or other information.

Have you had or do you have any:

	Question	YES	NO	Details
B1	Prolonged or repeated hospital admission and/or any surgery?	YES	NO	If YES, please give details.
B2	Heart or lung condition?	YES	NO	If YES, please give details.
B3	Kidney or bladder condition? Diabetes or Endocrine disorder?	YES	NO	If YES, please give details.
B4	Neurological condition, hearing or vision problems?	YES	NO	If YES, please give details.
B5	Physical, intellectual or development condition?	YES	NO	If YES, please give details.
B6	Gastrointestinal condition?	YES	NO	If YES, please give details.
B7	Psychiatric or addiction problems requiring medical treatment in last 10 yrs?	YES	NO	If YES, please give details.
B8	AIDS, Hepatitis B, Hepatitis C or positive HIV tests?	YES	NO	If YES, please give details.
B9	Tuberculosis (TB), treatment for TB and/or household and/or occupational contact with someone with TB?	YES	NO	If YES, please give details.
B10	Muscle, bone, skin, hereditary or autoimmune condition?	YES	NO	If YES, please give details.
B11	Cancer, malignancy or organ transplant? When?	YES	NO	If YES, please give details.
B12	Government assistance for medical, health or disability reasons?	YES	NO	If YES, please give details.
B13	Any prolonged clinical treatment or therapy in last 10 yrs?	YES	NO	If YES, please give details.
B14	Do you or have you ever smoked?	YES	NO	If YES, please give details.
B15	Do you consume alcohol?	YES	NO	If YES, please give details.

For female applicants only:

	Question	YES	NO	Details
B16	Are you pregnant?	YES	NO	If YES, please give details.
B17	Cervical smear history	YES	NO	If YES, please give details.
B18	Mammography report (if aged 45+)	YES	NO	If YES, please give details.

Name of Applicant

B21 Do you have any other condition that we need to know about? ☐ **YES** ☐ **NO**

If YES, please give details.

B22 List all medications and doses (Excluding contraceptive)

Drug Name	Dose	Quantity	Frequency

B23 Vaccination Status

Vaccine	Date given (if given)	Date Boosters given
Diptheria, Tetanus, Pertusis		
Polio		
Hib		
Hepatitis B		
Hepatitis C		
Measles, Mumps, Rubella		
Meningitis C		
Typhoid		
Yellow fever		
BCG		

Note: Vaccination requirements

The below is a list of the *minimum level* of vaccinations that are required:

- MMR – Measles, Mumps and Rubella
- Diphtheria
- Tetanus
- Pertussis
- Polio
- BCG

If you have not received these vaccinations or cannot evidence receiving them, you will be required to be vaccinated immediately on arrival in the Falklands.

Name of Applicant

Section C Physical Examination

This section must be completed by the examining physician who should answer all questions. Where abnormalities are indicated, please provide all relevant details in the space provided attaching any further notes and existing specialist reports.

GP/Doctor Declaration

Name and Address of Surgery

Telephone number/Email address

Full name of GP/Doctor

GMC NO. or equivalent professional body identifying number:

C1	Date of Examination			
C2	Height in Metres	Weight in Kilograms	BMI (Kg/m²)	
C3	Blood pressure	**Systolic**	**Diastolic**	
C4	Pulse rate and rhythm	**Normal**	**Abnormal**	Please give details.
C5	Bruits	**Normal**	**Abnormal**	Please give details.
C6	Peripheral pulses	**Normal**	**Abnormal**	Please give details.
C7	Heart sounds	**Normal**	**Abnormal**	Please give details.
C8	General appearance	**Normal**	**Abnormal**	Please give details.
C9	Cardiovascular system	**Normal**	**Abnormal**	Please give details.
C10	Respiratory system	**Normal**	**Abnormal**	Please give details.
C11	Ear, nose, throat	**Normal**	**Abnormal**	Please give details.
C12	Abdominal and genitourinary system	**Normal**	**Abnormal**	Please give details.
C13	Neurological system	**Normal**	**Abnormal**	Please give details.
C14	Psychiatric status	**Normal**	**Abnormal**	Please give details.
C15	Musculoskeletal system	**Normal**	**Abnormal**	Please give details.
C16	Evidence of Drug taking	**YES**	**NO**	If YES, please give details.

C17 **Please read attached GP/Physician letter**

In your opinion, *given the limited medical facilities in the Falklands with no specialist services on site*, is the applicant in good health, and able to live independently without significant support and assistance?

YES **NO**

If NO, please give details.

Examining physician:

I certify that this person has been examined by me or staff under my supervision and their identification presented has been examined to the best of my knowledge. I certify that the medical history information given in this application matches with any records (if held) on this person by this office. Tick here

Signature of GP/Doctor

Date

Issuing Authority Stamp

Name of Applicant

Declaration from Person completing this form

This section is to be completed by the applicant (or parent/guardian on their behalf if applicant under 16)

Personal Details of person completing this form

H1 Surname

H2 First Name/s

H3 Gender **Male** **Female** H4 Date of Birth

H5 Country of Birth Citizenship

H6 Passport Number Marital Status

H7 I am also a citizen, or used to be a citizen of

H8 Home Address Telephone

Email

H9 Please state the length of stay in the Falkland Islands

H10 Present occupation

- I understand the notes and questions in Section A and B of this certificate and I declare the information given is true, correct and complete.
- I declare that I will inform Falkland Islands Immigration of any relevant fact or any change in any circumstance that may affect the decision on this application due to health circumstances.
- I authorise the Falkland Islands Chief Medical Officer to make any enquiries they deem necessary in respect of the information provided on this form and to share this information with other Government agencies (including overseas agencies) to the extent necessary to make decisions about immigration status.
- I agree to undertake any further medical examination, including laboratory tests, that may be required in respect of the immigration application.
- I agree that the examining physician who completes this certificate, may release to the Chief Medical Officer any information acquired with regard to the health of myself or my child.
- **I understand that if I make any false statements or provide any false or misleading information, or if I change or alter this form in any material way after it has been signed, this application may be declined and I may lose the right to appeal the decision to decline this application. I may become liable for deportation. I may also be committing an offense the penalty for which may be a fine or imprisonment.**

Signature of person completing this form

Date

If completed by parent/guardian

Relationship to applicant

Name of Applicant

Declaration from Falkland Islands Government CMO and/or FIG Medical Practitioner

This section is to be completed by the applicant -

SURNAME:

FIRST NAME:

GENDER:

DATE OF BIRTH:

NATIONALITY:

This section must only be completed by the Falkland Islands Government Chief Medical Officer / FIG Medical Practitioner, when utilising the Medical Certificate Revised v3.4 (September 2021), who should tick the appropriate statement below:

Certified Medically Fit for:

A. Long term residence in the Falkland Islands (more than 5 years)

B. Short term residence in the Falkland Islands (less than 5 years) needs review with KEMH Doctor in ________ years/months.

C. Not Fit

*In the case of B. and C. please provide a report to the Principal Immigration Officer

1) Signature of FIG Medical Officer Date

2) Signature of FIG Medical Officer Date