



Falkland Islands
Government

Name of Applicant

MEDICAL CERTIFICATE

Revised v3.7 (October 2023)

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 v1.4 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 v1.4](#) 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 refused, any permit granted being revoked, 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 form will be assessed by the Falkland Islands Government Chief Medical Officer and this will then be passed to the Falkland Islands Customs & Immigration Service so that a decision can be made on your immigration permit application.

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 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 is 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.



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Name of Applicant

Medical Certificate Revised

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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)

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:

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

For female applicants only:

B16	Are you pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details.
B17	Cervical smear history	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details.
B18	Mammography report (if aged 45+)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If YES, please give details.

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
Diphtheria, Tetanus, Pertusis		
Polio		
Hib		
Hepatitis B		
Hepatitis C		
Measles, Mumps, Rubella		
Meningitis C		
Typhoid		
Yellow fever		
BCG		

Note: Vaccination requirementsThe 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.

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

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	<input type="text"/>
H2	First Name/s	<input type="text"/>
H3	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
H4	Date of Birth	<input type="text"/>
H5	Country of Birth	<input type="text"/>
	Citizenship	<input type="text"/>
H6	Passport Number	<input type="text"/>
	Marital Status	<input type="text"/>
H7	I am also a citizen, or used to be a citizen of	<input type="text"/>
H8	Home Address	<input type="text"/>
	Telephone	<input type="text"/>
	Email	<input type="text"/>
H9	Please state the length of stay in the Falkland Islands	<input type="text"/>
H10	Present occupation	<input type="text"/>

- 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 refused and I may lose the right to appeal the decision to refuse this application. I may become liable for deportation. I may also be committing an offence 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