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.

There are three locations authorized to perform examinations for immigrant visas, and you may have your exam done at the most convenient location for you.

MoBay Hope Medical Centre
Half Moon Shopping Village
Rose Hall, Montego Bay
St. James
(876) 953-3981

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

Dr. Althea Banbury
Dr. Michael Banbury
Medical Associates Hospital
18 Tangerine Place
Kingston 10
(876) 920-6362, 908-2123,
926-1400 or 781-6571

You must call ahead to schedule a specific appointment time with the doctor of your choice.

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.**

APPLICANT'S MEDICAL HISTORY & PHYSICAL EXAMINATION

Name*: (Last, First, M)*			Sex: ☐ Male ☐ 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.

NO	YES	
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
☐	☐	Heart disease
☐	☐	Hypertension
☐	☐	History of tobacco use Current use: ____ Yes ____ No
☐	☐	Asthma
☐	☐	Lung disease
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder (fits)
☐	☐	Major impairment in learning, self care, Intelligence, memory or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, mental retardation, schizophrenia)*
☐	☐	Current or past use of drugs (including ganja) not prescribed by a doctor
☐	☐	Other substance related disorders *(including alcohol addiction or abuse)*
☐	☐	Have you ever taken action to end your life?

NO	YES	
☐	☐	Have you ever caused serious injury to others, caused major property damage or had trouble with the law because of a medical condition, mental disorder, or the influence of drugs or alcohol?
☐	☐	Pregnancy
☐	☐	Last menstrual period date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _ _____
☐	☐	Diabetes mellitus (sugar diabetes)
☐	☐	Thyroid disease
☐	☐	History of malaria
☐	☐	Malignancy (cancer)
☐	☐	Kidney disease
☐	☐	Chronic hepatitis or chronic liver disease
☐	☐	Hansen's disease (leprosy)
☐	☐	Any disabilities, specify: _____ _____
☐	☐	Are you being treated for any medical problems? _____

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 ☐ X-Ray ☐ Medical Examination ☐

Vision	Uncorrected	L 20/	R 20/	BP	Pulse	Resp.
	Corrected	L 20/	R 20/			

Remarks: _____