



The Government of Antigua and Barbuda

Application for Registration as a Citizen of Antigua and Barbuda

Citizenship by Investment Program

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 photographic 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				A6. Gender				
		D	D	M	M	Y	Y	Y	Y	<input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis (A, B, or C) <input type="checkbox"/> Yes <input type="checkbox"/> No
Typhoid <input type="checkbox"/> Yes <input type="checkbox"/> No
Any Other Communicable Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Any Other heart condition (including congenital defects) <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> 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
---	------------------------------

[This section left deliberately blank]

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D4. Respiratory system – Any sign of abnormalities, including nose and lungs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D5. Cardiovascular system – Any signs of abnormalities, including pulse, blood pressure, heart murmurs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D6. Digestive organs and abdomen – Any signs of abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D7. Urogenital organs – Any signs of abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D8. Nervous system and sense organs – Any signs of abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D9. Musculoskeletal system – Any signs of abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D10. Endocrine system – Any signs of abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D11. Various – Any other signs of abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D12. Contagious disease – Any sign of contagious diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D12. 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. I confirm that the photograph below represents a true likeness to the person examined.	
Place and date	Signature of medical examiner
Stamp of medical examiner (if applicable)	<div data-bbox="986 1361 1311 1727" style="border: 2px solid black; padding: 10px; text-align: center;"><p>Attach Photograph here 35mm x 45mm</p></div>

[This page left deliberately blank]

