



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

<b>A1. Surname or Family Name</b> (as shown in passport)		<b>A2. First or Given Name(s)</b> (as shown in passport)	
<b>A3. Place of birth</b>	<b>A4. Country of birth</b>	<b>A5. Date of birth</b>	<b>A6. Gender</b>
		<div> <div>D</div> <div>D</div> <div></div> <div>M</div> <div>M</div> <div></div> <div>Y</div> <div>Y</div> <div>Y</div> <div>Y</div> </div>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>A7. Principal Residential Address</b>		<b>A8. Passport details</b> – Issuing Country and Passport Number	
<b>A9. Name of main physician or doctor</b>		<b>A10. Address of main physician or doctor</b>	

## 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**.

<b>B1. Past / Present Conditions: Have you had, or do you presently have, any of the following conditions:</b>
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
<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS / HIV
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

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.

<b>Place and date</b>	<b>Signature of applicant</b>

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

**[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

<b>D1. Weight (in kg)</b>	<b>D2. Height (in cm)</b>
<b>D3. Skin – Are there any signs of skin disease?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D4. Respiratory system – Any sign of abnormalities, including nose and lungs?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D5. Cardiovascular system – Any signs of abnormalities, including pulse, blood pressure, heart murmurs?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D6. Digestive organs and abdomen – Any signs of abnormalities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D7. Urogenital organs – Any signs of abnormalities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D8. Nervous system and sense organs – Any signs of abnormalities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D9. Musculoskeletal system – Any signs of abnormalities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D10. Endocrine system – Any signs of abnormalities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D11. Various – Any other signs of abnormalities?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D12. Contagious disease – Any sign of contagious diseases?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D13. Final evaluation</b>	

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**

<b>E1. Full name of medical examiner</b>	
<b>E2. Organization</b>	
<b>E3. Position</b>	
<b>E4. Address</b>	
<b>E5. Telephone number</b>	<b>E6. Fax number</b>

<b>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.</b>	
<b>Place and date</b>	<b>Signature of medical examiner</b>
<b>Stamp of medical examiner (if applicable)</b>	

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