

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

A1. Surname or Family Name (as shown in passport)		A2. First or Given Name(s) (a	s shown in passport)
A3. Place of birth	A4. Country of birth	A5. Date of birth	A6. Gender
		D D M M Y	✓ ✓ ✓ ✓ Male ☐ Female
A7. Principal Residential Address		A8. Passport details – Issuing	Country and Passport Number
A9. Name of main physician or doctor		A10. Address of main physic	ian 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		
□ Yes □ No		
Hepatitis (A, B, or C)		
□ Yes □ No		
Typhoid		
□ Yes □ No		
Any Other Communicable Disease		
□ Yes □ No		
Any Other heart condition (including congenital defects)		
□ Yes □ No		
Stroke		
□ Yes □ 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 \(\precedit \) 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

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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?	_	
□ Yes □ No		
D4. Respiratory system – Any sign of abnormalities, include	ling nose and lungs?	
□ Yes □ No		
D5. Cardiovascular system – Any signs of abnormalities, in	ncluding pulse, blood pressure, heart murmurs?	
□ Yes □ No		
D6. Digestive organs and abdomen – Any signs of abnorm	alities?	
□ Yes □ No		
D7. Urogenital organs – Any signs of abnormalities?		
□ Yes □ No		
D8. Nervous system and sense organs – Any signs of abno	ormalities?	
□ Yes □ No		
D9. Musculoskeletal system – Any signs of abnormalities?		
□ Yes □ No		
D10. Endocrine system – Any signs of abnormalities?		
□ Yes □ No		
D11. Various – Any other signs of abnormalities?		
□ Yes □ No		
D12. Contagious disease – Any sign of contagious disease	es?	
□ Yes □ No		
D13. Final evaluation		

Please tick here 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
E3. Telephone number	Eo. Fax Humber
I hereby confirm that I have identified, questioned and e best of my knowledge and in good faith.	xamined the applicant and have answered all questions to the
Place and date	Signature of medical examiner
Stamp of medical examiner (if applicable)	
Stamp of medical examiner (if applicable)	
	Attach Applicant's
	Photograph here
	35mm x 45mm

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