Photograph
Please attach a recent passport-sized photograph here for each applicant.

MEDICAL REPORT FORM – REGISTRATION OF SKILLED PROFESSIONAL ACT ('Act') 2016

IMPORTANT NOTES

1. This medical certificate form must be completed in English by a Registered Medical Practitioner for each person applying to stay in the Fiji for more than 6 months.
2. This certificate must be under 3 months old at the time of lodgment.
3. Each applicant must produce evidence of identification, such as passport, to the Medical Examiner.
4. Fees for the medical examination are payable by the applicant or their sponsor.

A. PERSONAL DETAILS OF THE APPLICANT

1. Name(s) as shown in the passport:

Surname: Given Names:

2. Full residential address:

3. Gender: Male ☐ Female ☐ 4. Date of Birth:

4. Passport number:

B. APPLICANT'S MEDICAL RECORDS

1. Has the applicant ever been hospitalized in the last 10 years or undergone surgery of any kind:

Yes ☐ No ☐

2. Has the applicant ever been refused employment, insurance, military service or entry to another country on medical grounds:

Yes ☐ No ☐

3. Does the applicant have any history of dependency on drugs, alcohol or other controlled substances: Yes ☐ No ☐
4. Has the applicant or any member of his/her family ever suffered from any mental disorder, fits or epilepsy: Yes ☐ No ☐
C. *EXAMINATION RESULTS*
1. HEART:
2. LUNGS:
3. KIDNEY:
4. LIVER:
5. EYES
6. X-RAY:
7. BLOOD HBG% SUGAR DEPOSIT
D: *APPLICANT'S DECLARATION:*
1. I declare that the details given by me on this form to the medical examiner are true and correct in every respect.
2. I agree that I will undergo, at my expense, any further medical examinations that may be required by the Skilled Professionals Evaluation Committee
3. I authorize that the medical examiner who completes this form to release to Skilled Professionals Evaluation Committee, or its medical consultants, any information acquired with regard to this examination.
4. I agree that all the information contained in this form is to evaluate my application under the Act.

SIGNATURE OF APPLICANT: …….. DATE: ……	**SIGNATURE OF EXAMINER AS WITNESS:** …… DATE: …….
PART X: *MEDICAL EXAMINER'S DECLARATION:*	
1. I have confirmed the identity of the applicant from his/her passport, identification papers and appearance.	
2. I am satisfied that the particulars submitted by the applicant are true and correct.	
3. The statements made by me in answer to all questions in this form are true to the best of my knowledge and belief.	
4. I certify that the applicant is medically fit/not medically fit to reside and work in Fiji.	
SIGNATURE OF MEDICAL EXAMINER: ……. DATE: ……	
MEDICAL EXAMINER STAMP/SEAL:	