



## Kiribati Immigration Medical Form

Each applicant for entry to Kiribati must have an acceptable standard of health. This form records information about your health that Kiribati Immigration requires to assess whether you meet this standard.

You must use this form if you are applying for a temporary visa for Kiribati and you intend to stay for longer than 12 months (unless you are applying for a military visa, or diplomatic, consular or official visa).

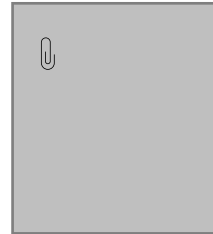
You may not need a new medical form if you have submitted a completed medical form within the last 36 months with a previous application, and that information has been retained by Kiribati Immigration.

### Section A: Applicant's personal details

Attach one recent colour passport-size photograph of yourself here.

The photograph must be less than six months old.

Write your full name on the back of the photograph.



**Examining physician (or delegated staff member):** please certify identity of applicant by sighting another form of photographic identification, e.g. passport or driver licence.

*Note: if identity cannot be confirmed, you should not proceed with this examination.*

Confirmed identity? Yes

Physician's initials: \_\_\_\_\_

### A1. Name as shown in passport

Family/last name:		Given/first name(s):			
Title:	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Ms <input type="checkbox"/>	Miss <input type="checkbox"/>	Dr <input type="checkbox"/>
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of birth (DD/MM/YY):	/ /	
Town/city of birth:			Country of birth:		

### A2. Passport details

Passport Number:		Country of Issue:		Expiry date (DD/MM/YY):	/ /
Other citizenships you hold:					

### A3. Which visa are you applying for?

Visitor <input type="checkbox"/>	Student <input type="checkbox"/>	Worker <input type="checkbox"/>	Other <input type="checkbox"/> Type: _____
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### A4. How long are you intending to stay in Kiribati?

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## Section B: Medical History

### Applicant:

- You may complete the medical history section yourself and discuss your history with your examining physician, or your examining physician may complete the medical history section with your assistance.
- If this health examination is for a child under 18 years of age, the medical history section must be completed by a parent or guardian, or the examining physician with the assistance of a parent or guardian.
- If you answer 'yes' to any question, please give details and give the physician any reports, tests or other information.

**Examining physician:** If the medical history section has been completed before the examination begins, you must confirm each of the answers with the applicant. Do not assume that the applicant has understood the questions.

<b>B1.</b> Have you ever been diagnosed with Tuberculosis (TB)? Have you ever had to take treatment for TB?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B2.</b> Have you ever been in close contact at home with a person known to have TB?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B3.</b> Have you ever had prolonged medical treatment and/or hospital admissions for any reason, including a major operation or psychiatric illness?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B4.</b> Do you suffer, or have you ever suffered, from a psychological or psychiatric disorder (including major depression, bipolar disorder, or schizophrenia)?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B5.</b> Have you ever had an abnormal or reactive HIV blood test?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B6.</b> Have you ever had an abnormal or reactive Hepatitis B or Hepatitis C blood test?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B7.</b> Do you have or have you had cancer or malignancy in the last 5 years?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B8.</b> Do you have diabetes?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B9.</b> Do you have a heart condition including coronary disease, hypertension, valve, or congenital disease?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B10.</b> Do you have a blood condition (including thalassemia)?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B11.</b> Do you have bladder or kidney problems?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B12.</b> Do you have an ongoing physical or intellectual disability affecting your current or future ability to function independently or be able to work full-time (including autism or developmental delay)?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B13.</b> Do you have an addiction to drugs or alcohol?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B14.</b> Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the counter medication and natural supplements)?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	

<b>B15.</b> Do you have a hereditary or autoimmune condition	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B16.</b> Do you have a neurological condition, including having had a stroke or multiple sclerosis?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B17.</b> Do you have any significant family health history?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	
<b>B18</b> Are you pregnant? What is the expected date of delivery?	No <input type="checkbox"/> Yes <input type="checkbox"/> <i>Give details</i>	

<b>Examining physician:</b> I have discussed the applicant's medical history with the applicant (or the applicant's parent or guardian if they are under 18 years of age).	Yes <input type="checkbox"/>
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**Physician's comments (if any):**


**Section C. Examining physician's declaration**

*This declaration must be signed and dated by the examining physician responsible for this examination. Please read carefully before signing. Please write name and other details below.*

I certify that this person has been examined by me or staff under my supervision and their identification in terms of papers, photographs and appearance has been confirmed.  
 I certify that the statements my staff and I have made in answer to all the questions are true, correct, and complete to the best of my knowledge.  
 I certify that all tests, investigations and reports I have considered are signed by me and securely attached.

Date: \_\_\_\_\_

Signature of examining physician \_\_\_\_\_

Full name of examining physician: \_\_\_\_\_

Place of examination (city/state and country):		_____	
Postal address:	_____		
Telephone Number/s:	_____	Email:	_____
Would you like Kiribati Immigration to contact you about this examination?			Yes <input type="checkbox"/> No <input type="checkbox"/>

**Section D: Declaration of person having the medical examination**

*This declaration must be signed and dated by the person being examined in the presence of the examining physician. A parent or guardian must sign on behalf of a child under 18 years of age. Please read carefully before signing.*

I declare that the information that I have provided in terms of my medical history and during my immigration health examinations is true, complete, and correct.

I understand that:

- my personal details and health information are being collected to enable Kiribati Immigration to determine whether they are satisfied that I meet the health criteria for a Kiribati visa
- Kiribati Immigration may enter and store my personal details and health information into their records system
- Kiribati Immigration is authorised to collect and use my personal information under the Immigration Act 2019 and regulations made under that Act
- if I have provided any false or misleading information, my visa application(s) may be declined, and I may become liable for deportation. I may also be committing an offence and I may be imprisoned
- I must inform Kiribati Immigration of any relevant fact or any change of circumstance that may affect the decision on my application for a visa due to my health circumstances
- Kiribati Immigration will retain my personal information for use in assessing my health in the future as necessary, or for audit reasons.

I also understand that my personal information (including medical results and photographs) may be disclosed to:

- Kiribati Government health agencies and examining physician(s)
- Kiribati Government agencies entitled to receive this information by law, if necessary, to make decisions about my immigration status; and
- Kiribati law enforcement and health agencies and international agencies.

I consent to:

- Kiribati Immigration retaining my medical information beyond the determination of my visa application, for the purposes of considering future applications I may make for a visa to Kiribati
- Kiribati Immigration storing my photograph(s) and using them for client identification purposes in addition to the health examination process where Kiribati Immigration deems it necessary
- Kiribati Immigration making any enquiries it deems necessary in respect of health information I have provided and to share this information with other Government agencies (including overseas agencies), and for these agencies to provide information about my health to Kiribati Immigration, if necessary to make decisions about my immigration status
- any Kiribati health service agency providing information about my state of health to Kiribati Immigration; and
- Kiribati Immigration disclosing my medical information in accordance with the provisions above.

I undertake to pay the fees for this medical examination and I also agree that I will undergo, at my expense, any further medical examination(s) that may be required in respect of the immigration application.

Date:

\_\_\_\_\_  
Signature of person being examined

Date:

\_\_\_\_\_  
Signature of parent or guardian if person being examined is under 18 years of age

Full name of parent or guardian (if applicable): \_\_\_\_\_

Relationship to person being examined: \_\_\_\_\_