TE MARAE ORA
Cook Islands Ministry of Health
PO Box 109, Rarotonga, Cook Islands.
Phone: (682) 29 664, Fax: (682) 23109
Website: www.health.gov.ck

POLICY FOR EXPATRIATE WORKERS MEDICAL SCREENING
JUNE 2016

Policy Statement:

The intent of this policy is to protect the public from the importation of infectious diseases into the Cook Islands including chronic diseases that will have a negative impact on the resources of the Cook Islands. These diseases have the potential to spread throughout the population and place a heavy burden on the country's resources. This policy applies to all persons applying for or intending to apply for entry permits to work in the Cook Islands for more than 31 days. In order to minimize the negative impact on the resources, sponsors/employers will be required to execute an Agreement with the Ministry of Health.

The Ministry of Health is mandated by Part 11 (Notifiable Conditions and Dangerous Conditions) and Schedule 2, of the Public Health Act 2004 (as amended) and by the Entry Residence and Departure Act 1971 - 72 to screen expatriate workers for any of the diseases listed.

Reasons for the Policy:

The policy cites the Ministry of Health's mission of 'accessible and affordable health care of the highest quality for all' and its goal of 'protecting public health by providing quality health services'.

A few expatriate workers arriving into the Cook Islands are from high-risk countries for Tuberculosis (TB), HIV/AIDS, Hepatitis A, B, C, D, and Sexually Transmitted Infections, notably Syphilis. This policy addresses the Ministry's mission statement and prevents the entry of people with notifiable diseases into the Cook Islands and allows for early identification to mitigate any consequences of a person arriving with a notifiable disease.

Principles:

The Ministry's values and principles of Integrity, Respect, Equity, Accountability and being People Focussed provides the basis for this policy. All expatriate workers are expected to have medical insurance to the satisfaction of the Ministry. In the long term the Ministry may consider the lack of medical insurance cover, un-immunized children, severe mental disorder and conduct disorder (alcohol, drug abuse, serious sexual deviance) as legitimate reasons for refusing entry into the Cook Islands.

Contact Information:

	Office	**Telephone**	**Website**
Policy Clarification & Interpretation	Director of Community Health Services, Ministry of Health, Cook Islands	(682) 29110	www.health.gov.ck
Administration	Administration officer, Community Health	(682) 29110	www.health.gov.ck

	Services Directorate, Ministry of Health, Cook Islands		

Responsibility:

Responsible Party:	**Responsibilities:**
Applicant / Sponsor / Employer	1. Submit the completed Medical and Chest X-ray (IMM18) form to Administration officer; 2. Original documentation only will be accepted (Medical and Chest X-ray (IMM) form, passport photos, laboratory, X-ray and relevant reports); 3. Ensure the top of each page is signed by the examining Doctor; and that all sections of the form are completed; 4. Incomplete forms or missing reports will be returned for re-submission; 5. Pay the necessary fees; 6. Provide proof of Medical Insurance to the satisfaction of the Ministry of Health. 7. In the absence of medical insurance execute the Agreement for the payment of any and all hospital fees for the applicant / employee; 8. On the renewal of the annual work permit with the Department of Immigration the applicant is to complete another medical check.
Any overseas "Accredited" Practitioner or Registered clinician within a hospital/health center or clinic setting. Cook Islands registered Medical Doctors including registered Private Practitioners (in country)	1. Provide Medical Registration number and place of employment to accompany medical form; 2. Complete all areas of the medical form, sign the top-right hand corner of each page; 3. Provide a signed chest X-ray report and laboratory report; 4. All applicants aged 16 years and over are tested for HIV, Hepatitis B, Syphilis and Mantoux; 5. Applicants under the age of 16 years must provide an Immunization schedule with the Medical form; 6. Hand over the completed form and reports to the applicant; 7. Provide further information as required by the Medical referee.
Administration officer	1. Receives and date-stamps applications received from the applicant / sponsor / employer; 2. Register the applicants in a log-book indicating name, contact number of applicant / sponsor / employer, and date of receipt of application; 3. Collect and receipt fees received; 4. Lock money in a safe place; 5. At end of each business week, reconcile and deposit

	money with Finance division ensuring receipt book is signed by receiving Finance officer; 6. Verifies Medical Examiners registration prior to submission of forms to Medical referee; 7. Receive 'checked' forms from Medical referee; 8. If approved by Medical referee, contact applicant / sponsor / employer to collect signed approval letter for Department of Immigration; 9. Check receipt of medical insurance policy and that it meets the requirements for cover of the employee while living in the Cook Islands. If there is no medical insurance policy, the Deed of Agreement is executed; 10. Ensure sponsor / employer executes Deed of Agreement for the payment of any and all hospital fees for the applicant / employee. 11. If not approved by Medical referee, contact applicant / sponsor / employer and request information required; 12. Ensure proper file management of all application forms to assist with retrieval for possible investigation if and when required.
Medical Referee (Director of Community Health Services or appointed nominee)	1. Thoroughly reviews all applications according to fees paid: $300 – immediate; $150 – within 5 working days $100 – within 10 working days $50 – for each child of applicants under the age of 16 years 2. Due diligence must be applied to each medical report. 3. Pay close attention to questions on infectious and chronic diseases, mental disorders that may place a burden on health services and resources; 4. Review laboratory, X-ray and specific HIV, Mantoux and Consultant reports; 5. Request additional supporting information as required; 6. Approve application submitted; 7. Approval letter is provided to the sponsor/employer for submission to the Department of Immigration; 8. If applications are to be declined a letter is forwarded to applicant /sponsor/employer that the applicant failed to meet expected standards for medical clearance; 9. Make time for personal or telephone inquiries to applicant / sponsor / employer and raise any issues of concern; 10. Reject fraudulent applications outright (there is no recourse for rechecks).

Notifiable and Chronic Diseases

Disease	Expected Results
Tuberculosis (TB)	1. Negative, reaction < 5mm. PPD or Tuberculin or Mantoux test. 2. Clear radiological (chest xray) report. 3. For suspicious lesions or dormant tubercle's, an electronic image is sent to the WHO Tb consultant, Australia, for a second opinion. 4. The applicant may be required to supply the image. NB. PPD test is positive 6wks post-infection. It does not inform between active and dormant tb.
HIV (Human immunodeficiency Virus)	1. Non reactive to both HIV-1 and HIV-2. NB. Most if not, all tests detect the presence of antibodies NOT antigens. Beware of the 'window' period* Type 1 (USA) Type 2 (West Africa)
Hepatitis B virus	1. Negative for Hepatitis B surface antigen (HBsAg) NB. Presence indicates **active** infection. Persistently high levels is considered a **carrier.** 2. Presence of Hepatitis B surface antibody (HBsAb) signify the end of acute phase or immunity.
Syphilis Treponema pallidum (a spirochete)	1. Negative or Non reactive. VDRL or Wasserman's test detects antibodies. RPR more sensitive. Both are non-treponemal specific thus have high false positive. VDRL is positive 2 wks after inoculation. 2. TPHA test are performed in other countries.

- Denotes the period between Inoculation and detection of antibodies - usually 12 weeks or more. Tests done during the 'window' period may need to be repeated after 2-3 months, if there is strong suspicion of infection.
- In some cases Hepatitis B antigen may be negative for up to 3 months following exposure. Repeat test if indicated.
- Antibodies to Hepatitis C is detectable 8 weeks post exposure, however, sero-conversion may take up to 6 months. Repeat test if indicated.

AGREEMENT

THIS AGREEMENT is made on the day of 20

BETWEEN:

Her Majesty the Queen in right of the Government of the Cook Islands by and through the Minister of Health ("the Ministry")

AND

(Name) of (Foreign and Cook Islands Addresses)

("the Sponsor/Employer")

WHEREAS:

A. The Sponsor/Employer wishes to sponsor/employ an expatriate worker to enter the Cook Islands to work and reside under an entry permit status to be issued by the Ministry of Foreign Affairs and Immigration.
B. The expatriate worker and that person's family as appropriate does not and will not have health or medical insurance during the time that person is resident in the Cook Islands

IT IS AGREED AS FOLLOWS:

1. The Sponsor/Employer must pay to or reimburse to the Ministry all charges and fees incurred for any medical, hospital or other health services including any international referral for further care services provided to:

    a. the expatriate worker during the time that the expatriate worker is resident in Cook Islands; and

    b. any member of the expatriate worker's family during the time that the members of the expatriate worker's family are resident in the Cook Islands

2. For the purposes of this Agreement, an expatriate worker is deemed to reside in Cook Islands for the entire duration of the permit granted to the worker, whether or not the worker is actually present in Cook Islands during that period.

3. The sponsor/employer's obligations under this agreement continues despite the termination of the worker's permit and the departure of the worker from the Cook Islands until all charges or fees owing have been paid.

SIGNED

…….. Print name:
For the Ministry of Health Designation:
Date:

In the presence of: (witness)

…… Print name:
Designation:
Date:

SIGNED

…….. Print name:
Sponsor/Employer/Representative of Business Designation:
Sponsor or Employer Address:
Phone:
Email:
Date:
Common seal of Business:

In the presence of: (witness)

…….. Print name:
Designation:
Date:

IMM 18
MARCH 2009

FOR ICI USE

Application number	
Client number	
Date received	/ /

MEDICAL AND CHEST X–RAY FORM

SECTION A: GENERAL INFORMATION AND PERSONAL DETAILS

Who can complete this certificate?

In countries where Immigration Cook Islands has an approved list of Panel Doctors and Radiologists this certificate must be completed by a listed medical practitioner and a radiologist. Please see our website: www.mfai.gov.ck for a list of Panel Doctors near you. If you are in a country where there are no Panel Doctors, a registered medical practitioner, preferably your own General Practitioner, can complete this certificate.

What to bring to the medical examination

- Your valid passport for identification.
- Any spectacles or contact lenses you may wear.
- Any existing specialist reports, where you have a known medical condition.
- Details of any prescription medicines you are currently taking.
- Three recent passport photos (less than 6 months old).

Children

All applicants including children and newborn babies are required to undergo a medical examination and have a medical certificate submitted as part of the application process.

- Children under 11 are not required to undergo a chest X-ray.
- Children under 15 are not usually required to undergo the standard blood tests.
- Children under 16 must be accompanied by a parent or guardian for the medical examination.

Your responsibilities

- The applicant must pay for the examination, the chest X-ray, laboratory tests, and any specialist reports which are required.
- You must tell the truth. Any false statement on this form may result in the application being declined, any visa or permit issued being cancelled and the applicant being required to leave Cook Islands.

What happens next?

You are required to submit this completed form including chest X-ray and laboratory results with your application for a visa or permit. The medical certificate will not be accepted more than three months after the medical examiner has signed the declaration. Immigration Cook Islands may follow-up your submission with a request for further information in the form of specialist reports or further tests.

Instructions for Section A:

- **To be completed by the person being examined before having the medical examination.**
- Please use a black pen and write neatly in English using BLOCK LETTERS.
- Illegible forms will be returned for clarification.
- Please tick or fill in all boxes.

Applicant:

Please attach one recent passport photograph in the space provided.

Medical Examiner (or staff)

Valid photographic identification sighted? (e.g. passport) ☐

Medical Examiner to certify identity by placing signature and date across photograph without obscuring the likeness of the person.

A1 Passport number

A2 **Your full name** (as it appears in your passport)

Surname or family name

First or given names

Other names you are known by

A3 Full home address

A4 Daytime telephone number

(COUNTRY CODE) (AREA CODE)

A5 Email address

A6 Gender Male ☐ Female ☐

A7 Date of birth DAY / MONTH / YEAR

A8 Country of birth

A9 Country of citizenship

Medical Examiner's initials

A10 Number of children born to applicant.

Alive	Deceased	Total born

A11 List the countries in which you have lived, studied or worked for three months or more in the last five years.

A12 State your occupation and the types of activities you will be performing during your intended work or course of study in Cook Islands?
e.g. Office work, Labouring.

A13 Do you receive a sickness benefit, government assistance, or any other welfare benefit for health or disability reasons? No ☐ Yes ☐ >

If yes, please give details of diagnosis, duration of payment, date last employed, restrictions on ability to work and outlook for future.

SECTION B: MEDICAL HISTORY OF PERSON HAVING THE MEDICAL EXAMINATION

Instructions for Section B:
- **This section must be completed in the presence of the medical examiner or delegated staff member.**
- All questions must be answered.
- If you answer 'Yes' to any of the questions, please provide all the relevant details in the space provided and attach any existing specialist reports you might have.
- If there isn't enough space, attach a separate sheet, signed by the medical examiner.

If yes please provide details.

B1 Have you ever received hospital treatment or been in hospital for any reason? No ☐ Yes ☐ >

B2 Have you ever undergone or been advised to have surgery? No ☐ Yes ☐ >

B3 Have you ever had a blood transfusion? No ☐ Yes ☐ >

B4 Do you have any physical, mental, communication, developmental, or intellectual disabilities which may affect your ability to earn a living or take full care of yourself now or in later life? No ☐ Yes ☐ >

B5 If you are under 21 years of age, are you in a special class or a special school, or are you receiving special support services or not at school because of a disability? No ☐ Yes ☐ >

Medical Examiner's initials

B6 If you are on medication and/or undergoing treatment, please list all medication and/or treatment. (*Examples shown).

Drug name and/or treatment	Diagnosis	Dose	Quantity	Frequency	How long
*Aspirin		100mg	2	Daily	10 years
*Physiotherapy		-	1	Weekly	6 months

If yes please provide details.

B7 Do you smoke or have you ever smoked cigarettes? No ☐ Yes ☐ >

- If yes, how many per day? >
- For how many years? >
- If you have stopped, how many years ago did you stop? >
- Calculate your pack year history (packs of 20 cigarettes per day) x (number of years smoked) >

B8 Do you drink alcohol? No ☐ Yes ☐ >

- If yes, what do you drink? >

  What number of drinks per week? >

B9 Have you ever been addicted to a drug or taken drugs illegally? No ☐ Yes ☐ >

Do you have or have you ever had:

If yes, please provide details, including date of diagnosis and any treatment received.

B10 Tuberculosis (TB), an abnormal chest X-ray, chronic cough, coughed up blood, or had close contact with a person with TB? No ☐ Yes ☐ >

B11 An infectious or communicable disease lasting more than 2 weeks? No ☐ Yes ☐ >
e.g. typhoid, hepatitis, jaundice, rheumatic fever, HIV, AIDS or AIDS-related conditions.

B12 High blood pressure, heart trouble, or chest pain? No ☐ Yes ☐ >

Medical Examiner's initials

	Do you have or have you ever had:		If yes, please provide details, including date of diagnosis and any treatment received.
B13	Asthma, shortness of breath, sleep apnoea, difficulty in breathing, a chronic cough?	No ☐ Yes ☐ >	
B14	Recurrent abdominal pains, indigestion, heartburn, liver disease, or bowel trouble?	No ☐ Yes ☐ >	
B15	Kidney, bladder, urinary or prostate problems?	No ☐ Yes ☐ >	
B16	Diabetes or sugar in the urine?	No ☐ Yes ☐ >	
B17	Epilepsy, fits, faints, blackouts or dizziness?	No ☐ Yes ☐ >	
B18	A nervous or mental illness? e.g. depression, anxiety, schizophrenia, bipolar or eating disorder?	No ☐ Yes ☐ >	
B19	Chronic ear disease or difficulty hearing?	No ☐ Yes ☐ >	
B20	Eye disease or difficulty seeing?	No ☐ Yes ☐ >	
B21	Arthritis or pain in the back, neck or any joint that has required treatment and/or time off work?	No ☐ Yes ☐ >	
B22	Skin disease?	No ☐ Yes ☐ >	
B23	Anaemia, abnormal bleeding or congenital immune deficiency?	No ☐ Yes ☐ >	
B24	Any cancer or malignancy, including lymphoma or leukaemia?	No ☐ Yes ☐ >	
B25	A genetic, chromosomal, congenital or familial disorder? e.g. Huntington's chorea, hyperlipidaemia, muscular dystrophies, cystic fibrosis.	No ☐ Yes ☐ >	
B26	Any other illness, injury, medical condition or disability (including intellectual) not mentioned above that has lasted more than two weeks or is recurring?	No ☐ Yes ☐ >	

Medical Examiner's initials

For females only: have or have you ever had:

B27 Any reproductive system disorders, including abnormal cervical smears? No ☐ Yes ☐ >

B28 What was the date of your last menstrual period? > DAY / MONTH / YEAR

B29 Are you pregnant? No ☐ Yes ☐

If yes, expected date of delivery? > DAY / MONTH / YEAR

B30 Family history of person being examined.

Please complete the tables below detailing relationship, age and state of health of your parents, brothers and sisters. If any are deceased, please specify the age at death and cause of death. (If there is not enough space, please attach an additional sheet of paper and have this initialled by the Medical Examiner.)

Relationship (e.g. father, sister)	Age	**State of health** (if not good, please state reason)	**Cause of death if deceased** (please provide full details)	**Age at death**

Medical Examiner's comment (if any) on applicant's medical history:

SECTION C: DECLARATION OF PERSON HAVING MEDICAL EXAMINATION

Instructions for Section C:

- **This declaration must be signed and dated by the person being examined in the presence of the Medical Examiner.**
- A parent or guardian must sign on behalf of a child under 16 years of age.
- **Please read carefully before signing:**

I certify that:

- I understand the notes and questions in sections A and B of this certificate and I declare the information given about me is true, correct, and complete.
- I understand that this declaration also applies to the chest X-ray and laboratory test sections.
- I declare I will inform Immigration Cook Islands of any relevant fact or any change of circumstance that may affect the decision on my application for a permit or visa due to my health circumstances.
- I authorise Immigration Cook Islands to make any enquiries it deems necessary in respect of the information provided on this certificate and to share this information with other Government agencies (including overseas agencies) to the extent necessary to make decisions about my immigration status.
- I authorise Immigration Cook Islands to provide information about my state of health to any Cook Islands health service agency.
- I authorise any Cook Islands health service agency to provide information about my state of health to Immigration Cook Islands.
- I undertake to pay the fees for this medical examination including chest X-ray and laboratory tests and I also agree that I or my child will undergo, at my expense, any further medical examination(s) that may be required by Immigration Cook Islands in respect of the immigration application.
- I agree that the Medical Examiner, the radiologist and the laboratory who complete this certificate may release to Immigration Cook Islands, or any Medical Assessor employed by them, any information acquired with regard to the health of myself or my child.
- I understand that if I make any false statements, or provide any false or misleading information or have changed or altered this certificate in any way, my application may be declined, or my visa or permit may be revoked, and that I may be committing an offence and be liable to prosecution and imprisonment.

Signature of person being examined
(or parent/guardian)

Date DAY / MONTH / YEAR

Full name of parent or guardian

Relationship to person being examined

Declaration of person assisting:

I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

Signature of person assisting applicant (if applicable)

Name of person assisting

Date DAY / MONTH / YEAR

Signature of Medical Examiner

Name of Medical Examiner

Date DAY / MONTH / YEAR

PRIVACY

- The information about you on this certificate is collected to help determine your eligibility for a visa or permit.
- You will, if you come to the Cook Islands, have the rights provided under the Official Information Act 2008 to access personal information about you held by Immigration Cook Islands, and to ask for any of it to be corrected if you think that is necessary.
- The main recipient of the information is Immigration Cook Islands, but the information may also be shared with other government agencies which are lawfully entitled to it.
  The address of Immigration Cook Islands is PO Box 105, Avarua, Rarotonga, Cook Islands.
- The supply of the information is voluntary, but if you do not supply it then your application is likely to be declined.
- You can get more information and advice from:
  – Cook Islands diplomatic and consular offices.
  – The Immigration Cook Islands website at **www.mfai.gov.ck**.

Medical Examiner's initials

SECTION D: MEDICAL EXAMINATION AND FINDINGS

Instructions for Section D:

- **This section is to be completed by the Medical Examiner. Questions marked with an asterisk* may be completed by a delegated staff member.**
- All questions must be answered.
- Where abnormalities are indicated, please provide all the relevant details in the space provided and attach any existing specialist reports.
- If there isn't enough space, attach a separate sheet. All attached sheets must be initialled by medical examiner.
- Further information for Medical Examiners can be found at http://www.immigration.govt.nz/medicalhandbook/

- Was a chaperone present during the examination? Yes ☐ No ☐ Declined ☐
- Was an interpreter present during the examination? Yes ☐ No ☐ Declined ☐

If yes, please provide name and the relationship to person being examined.

D1 Date of examination — DAY / MONTH / YEAR

D2 **BMI***

In light weight clothing and stockinged feet:

If BMI > 35 in adults or > 97th percentile for applicants aged 15-19 years of age, or waist circumference of females ≥ 88cm, males ≥ 102cm, arrange and attach fasting lipids and fasting glucose tests. (Refer to the Handbook for Medical Examiners for further information)

Weight (kg)

Height (cm)

Waist circumference (cm)
(for applicants 20 years and over)

BMI (Weight (kg) / (Height (m)^2))
(for applicants 15 years and over)

D3 Head circumference* for children under 3 years (cm)

D4 **Vision**

- Visual Acuity*: Uncorrected Left / Right; Corrected Left / Right
- Any abnormalities of fundal examination? No ☐ Yes ☐ >

D5 **Cardiovascular system**

- **Blood pressure***
  (not required for children under 15 years of age)

  Where repeat readings after rest exceed the following limits, arrange fasting lipids and fasting glucose tests.
  - 40 years of age or less – 140/90 mmHg
  - 41-64 years – 150/90 mmHg
  - 65 or more years 160/90 mmHg

  / systolic diastolic

  / systolic diastolic

  / systolic diastolic

- **Heart** Pulse rate — Rhythm
  Murmur No ☐ Yes ☐ >
- Peripheral pulses (any absent)? No ☐ Yes ☐ >
- Any bruits in neck or abdomen? No ☐ Yes ☐ >
- Any other abnormality? No ☐ Yes ☐ >

Medical Examiner's initials

	Are there any abnormalities in the following:		If yes please provide details.
D6	**Respiratory system** (including nose and lungs)	No ☐ Yes ☐ >	
D7	**Gastro-Intestinal system**		
•	Mouth and oropharynx examination	No ☐ Yes ☐ >	
•	Abdomen (including hernia, organomegaly or abdominal masses)	No ☐ Yes ☐ >	
D8	**Central and peripheral nervous system**	No ☐ Yes ☐ >	
•	Any signs of abnormalities (including cranial nerves, sensation, power, tone, reflexes and muscle wasting)		
•	Any behavioural or communication problems?	No ☐ Yes ☐ >	
•	Any evidence of mental illness or abnormal mental state?	No ☐ Yes ☐ >	
•	Any critically delayed developmental milestones noted? (Please refer chart below – for children under five years of age or where concerned)	No ☐ Yes ☐ >	
•	Any disability or developmental delay evident that is likely to require support services?	No ☐ Yes ☐ >	
•	Any signs of impaired memory or impaired cognitive performance or dementia? If no signs noted and applicant is over 70 years of age please complete and attach a dementia screening assessment. (e.g. RUDAS or MMSE. Refer Handbook for Medical Examiners. Please comment on any factors that might influence interpretation).	No ☐ Yes ☐ >	
•	Is this person likely to require assessment for support services?	No ☐ Yes ☐ >	

Critically delayed developmental milestones

Milestones	Critically Delayed	Normal
Cannot hold head up unsupported	8 months or more	4 months
Cannot sit unsupported	10 months or more	8 months
Cannot walk	24 months or more	13 months
No words	24 months or more	13 months
No 2 – 3 word phrases	24 months or more	15 months
Moro reflex persisting at 8 months or older		

Medical Examiner's initials

Are there any abnormalities in the following:		If yes please provide details.
D9 Hearing Any hearing difficulty or ear disease?	No ☐ Yes ☐ >	
D10 Locomotor system (including gait and deformities of joints or limbs)	No ☐ Yes ☐ >	
D11 Lymph nodes	No ☐ Yes ☐ >	
D12 Endocrine system	No ☐ Yes ☐ >	
D13 Disorders of skin and scalp (including scars, sores and ulcers as well as skin cancers and eczema)	No ☐ Yes ☐ >	
D14 Genito-urinary system (consider E1 urinalysis)	No ☐ Yes ☐ >	
D15 Breast • Females 45 years and over and where otherwise indicated. (As an alternative to examination, applicants may supply a mammogram or breast ultrasound completed in the last six months).	No ☐ Yes ☐ >	
D16 General appearance (including anaemia and jaundice)	Normal ☐ Abnormal ☐ >	
D17 General medical comment • Are there any physical or mental conditions which may affect this person's ability to earn a living, attend a mainstream school, take care of themselves or adapt to a new environment now or in future adult life?	No ☐ Yes ☐ >	

Next Steps – Checklist

1. Medical Examiner to arrange urinalysis for all applicants five years of age and over. ☐
2. Medical Examiner to complete Laboratory Referral Form and detach for applicant to take when giving blood sample. ☐
3. Medical Examiner to consider noting any conditions which may be relevant to the radiologist when examining the X-ray. (Refer question K1 on the X-ray certificate.) ☐
4. Applicant to undergo blood tests and X-ray. ☐

Medical Examiner's initials

SECTION E: URINALYSIS AND BLOOD TESTS

Instructions for Section E:

- To be completed by the Medical Examiner on receipt of laboratory test results and urinalysis.
- Urinalysis may be completed via dipstick (by Medical Examiner) or via laboratory. Where dipstick results return abnormalities attach full laboratory urinalysis.
- Urinalysis is required for all persons (except children under five years of age).
- A child under five years of age should have urinalysis if clinically indicated e.g. a history of kidney disease or recent tonsillitis.
- The testing of females must not occur during menstruation.
- Tests for HIV, Hepatitis B, syphilis screening, liver function, full blood count and serum creatinine are compulsory for all applicants 15 years of age and over or where clinically indicated.
- Medical Examiner to sign and attach all test results.

E1 Urinalysis results

Date: DAY / MONTH / YEAR

Dipstick ☐ **Laboratory** ☐

			Details if appropriate.
Protein	Negative ☐	Positive ☐ >	
Sugar	Negative ☐	Positive ☐ >	
Blood	Negative ☐	Positive ☐ >	
If tested at a later date: DAY / MONTH / YEAR			
Protein	Negative ☐	Positive ☐ >	
Sugar	Negative ☐	Positive ☐ >	
Blood	Negative ☐	Positive ☐ >	

E2 Blood test results

Standard tests	**Results**		
HIV If the initial test is positive, please repeat and perform Western Blot.	Negative ☐	Positive ☐ >	
Hepatitis B antigen	Negative ☐	Positive ☐ >	
Syphilis	Negative ☐	Positive ☐ >	
Liver Function Test	Normal ☐	Abnormal ☐ >	
Full Blood Count	Normal ☐	Abnormal ☐ >	
Serum Creatinine	Normal ☐	Abnormal ☐ >	
Discretionary tests	Normal ☐	Abnormal ☐ >	
Hepatitis C	Normal ☐	Abnormal ☐ >	
Fasting lipids	Normal ☐	Abnormal ☐ >	
Fasting glucose	Normal ☐	Abnormal ☐ >	
HBA1c	Normal ☐	Abnormal ☐ >	
Creatinine/MicroAlbumin	Normal ☐	Abnormal ☐ >	
Faeces cultures	Normal ☐	Abnormal ☐ >	

Mantoux test or Interferon-Gamma Release Assays (IGRAs) to detect latent TB infection (LTBI) should be inserted under discretionary tests for high prevalence countries.

Normal ☐ Abnormal ☐

Medical Examiner's initials

SECTION F: MEDICAL EXAMINER'S SUMMARY OF FINDINGS

Summary Comments:

Please provide your comments (if any) on the health of this applicant, especially any areas where you consider follow-up is required. Please note any further tests or investigations that you would recommend.

Recommendation:

Please consider the information provided about this applicant. You must consider if there exists any significant finding on the history, the examination, the laboratory tests and the X-ray. A significant finding is one that should be further reviewed by the Immigration Cook Islands Medical Assessor. Note this is not an assessment of whether or not the applicant has an acceptable standard of health in relation to the Immigration Cook Islands standard.

1. No significant or abnormal findings ☐

2. Significant or abnormal findings ☐

SECTION G: MEDICAL EXAMINER'S DECLARATION

Instructions for Section G:

- **This declaration must be signed and dated by the Medical Examiner who was responsible for this examination.**
- This declaration must be signed after the Medical Examiner has sighted and considered the chest X-ray certificate and all medical test results.
- **Please read carefully before signing:**

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.
- 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.
- All tests, investigations and reports I have considered are signed by me and securely attached.

G1 **Signature of Medical Examiner**

G2 Date — DAY / MONTH / YEAR

Medical Examiner's Details (please print)

G3 Full name

G4 MCNZ number for New Zealand practitioners

G5 Place of examination (city/state and country)

G6 Postal address

G7 Daytime telephone number — (COUNTRY CODE) (AREA CODE)

G8 Email address

G9 Would you like Immigration Cook Islands to contact you about this examination? No ☐ Yes ☐

LABORATORY REFERRAL FORM

SECTION H: INSTRUCTIONS FOR MEDICAL EXAMINER AND LABORATORY

Instructions for Medical Examiner:

- Please complete your contact details.
- Please confirm which tests are required for this applicant.
- HIV, Hep B, Syphilis, LFT, FBC and Serum creatinine tests are compulsory for all applicants 15 years of age and over or where clinically indicated.
- Hepatitis C Antibody test is required where clinically indicated.
- Fasting glucose and fasting lipids are required if indicated by BMI, waist circumference or blood pressure (at questions D2 and D5).
- HBA1c and Creatinine MicroAlbumin Ratio tests are required for diabetics.
- Where other conditions are identified refer to Handbook for Medical Examiners.

Instructions for Laboratory:

- Please return this form and results to the requesting doctor.

Applicant's Details (please print)

H1 Applicant's full name

H2 Applicant's date of birth DAY / MONTH / YEAR

H3 NHI number (NZ)

H4 Gender Male ☐ Female ☐

H5 Medical Examiner's Laboratory Reference Number (if applicable)

LABORATORY TESTS REQUIRED

Standard tests		Discretionary tests	
HIV	☐	Urinalysis	☐
Hepatitis B surface antigen	☐	Hepatitis C Antibody	☐
Syphilis screening	☐	Fasting lipids	☐
Liver function tests	☐	Fasting glucose	☐
Full blood count	☐	HBA1c	☐
Serum Creatinine	☐	Creatinine MicroAlbumin Ratio	☐
		Faeces culture	☐
			☐
			☐
			☐

H6 **Signature of Medical Examiner**

H7 Date DAY / MONTH / YEAR

Medical Examiner's Details

H8 Full name

H6 Postal address

Ensure both sides of this form are complete.

SECTION I: CONFIRMATION OF IDENTITY AND DECLARATION

Instructions for Applicant:

- Please attach one recent passport photograph in the space provided.
- Please complete I1 – I6 before your examination.
- Please present this form when having blood taken for testing.
- **The declaration below must be completed and signed in front of the person taking blood.**

Person taking blood:

Valid photographic identification sighted? (e.g. passport) ☐

Person taking blood to certify identity by placing signature and date across photograph without obscuring the likeness of the person.

Applicant

I1 Passport number

I2 **Your full name** (as it appears in your passport)

Surname or family name

First or given names

Name you are known by

I3 Gender Male ☐ Female ☐

I4 Date of birth DAY / MONTH / YEAR

I5 Country of Birth

I6 Country of Citizenship

Applicant's Declaration:

- I certify that I have read and understood the declaration at section C on page 6.
- I understand that the declaration at that section also applies to the laboratory tests.

Signature of applicant
(or parent/guardian)

Date DAY / MONTH / YEAR

Full name of parent or guardian

Relationship to person being examined

Declaration of person assisting:

I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

Signature of person assisting applicant (if applicable)

Name of person assisting

Date DAY / MONTH / YEAR

Declaration of person taking blood:

I certify I have confirmed the applicant's identity in terms of papers, photographs and appearance.

Signature of person taking blood

Name of person taking blood

CHEST X–RAY SECTION

SECTION J: GENERAL INFORMATION AND CONFIRMATION OF IDENTITY

Instructions for Applicant:

- Please attach one recent passport photograph in the space provided.
- Please complete J1 – J6 before your examination.
- Please take this form when presenting for your chest X-ray
- **The declaration below must be completed and signed in front of the radiographer**

Instructions for Radiographer:

- Valid photographic identification sighted?

(e.g. passport) ☐

Radiographer to certify identity by placing signature and date across photograph without obscuring the likeness of the person.

Applicant

J1 **Your full name** (as it appears in your passport)

Surname or family name

First or given names

Other names you are known by

J2 Gender Male ☐ Female ☐

J3 Passport number

J4 Date of birth DAY / MONTH / YEAR

J5 Country of Birth

J6 Country of Citizenship

J7 Medical Examiner's name

Applicant's Declaration:

- I certify that I have read and understood the declaration at Section C on page 6.
- I understand that the declaration at that section also applies to the chest X-ray section

Signature of applicant (or parent/guardian)

Date DAY / MONTH / YEAR

Full name of parent or guardian

Relationship to person being examined

Declaration of person assisting:

I certify that I have assisted in the completion of this form at the request of the applicant and that the applicant understood the content of the form(s) and agreed that the information provided is correct before signing the declaration.

Signature of person assisting applicant (if applicable)

Full name of person assisting

Date DAY / MONTH / YEAR

Declaration of Radiographer or Examining Radiologist:

I certify I have confirmed the applicant's identity in terms of papers, photographs and appearance.

Signature of Radiographer or Examining Radiologist

Name of Radiographer or Examining Radiologist

SECTION K: RESULTS OF CHEST X-RAY FILM EXAMINATION

Instructions for Section K:

- **This section is to be completed in full by the radiologist.**
- All questions must be answered.
- Please answer all questions in English.
- Please print or write clearly. Illegible forms will be returned for clarification. Please use a black pen.
- Where abnormalities are present, the radiologist must provide details and comments in the space provided.
- Where abnormalities are present, the X-ray film must accompany the certificate.
- The radiologist's report must be attached to this certificate and both returned to the Medical Examiner.

K1 Notes to Radiologist (if applicable)

			If abnormalities, please provide details.
K2	**Skeleton and soft tissue**	Normal ☐ Abnormal ☐ >	
K3	**Cardiac Shadow**	Normal ☐ Abnormal ☐ >	
K4	**Hilar and Lymphatic glands**	Normal ☐ Abnormal ☐ >	
K5	**Hemidiaphragms and costophrenic angles**	Normal ☐ Abnormal ☐ >	
K6	**Lung fields**	Normal ☐ Abnormal ☐ >	
K7	**Evidence of TB**	No ☐ Yes ☐ >	
K8	**Evidence of old, healed TB**	No ☐ Yes ☐ >	
K9	**Evidence suspicious of active TB**	No ☐ Yes ☐ >	
K10	**Details of other abnormalities**	>	

SECTION L: RADIOLOGIST'S DECLARATION

Instructions for Section L:

- **This declaration must be signed and dated by the radiologist who examined the chest X-ray film.**
- **Please read carefully before signing:**

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.

L1 **Signature of Radiologist**

L2 Date (DAY / MONTH / YEAR)

Radiologist's Details (please print)

L3 Full name

L4 MCNZ number for Cook Islands practitioners

L5 Place of examination (city/state and country)

L6 Postal address

L7 Daytime telephone number (COUNTRY CODE) (AREA CODE)

L8 Email address