



General Medical Certificate

Section A Personal details

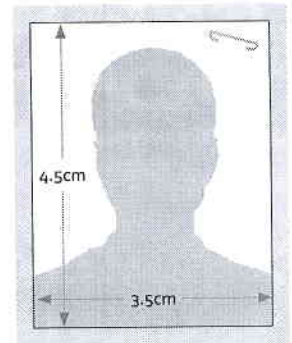
Question **A1** must be completed by the examining physician or delegated staff.

All other questions in this section must be completed by the applicant before the examination.

Please use a black pen and write neatly in English using CAPITAL LETTERS. Illegible forms will be returned for clarification.

Tick or fill in all boxes.

Attach one recent passport-size colour photograph of yourself in the space provided. The photograph must be no more than six months old. Write your full name on the back of the photograph.



A1 Examining physician (or delegated staff member): certify identity by placing signature and date across photograph without obscuring the likeness of the person.

Valid photographic identification sighted? (for example, passport)

Type of identity document:

Original Passport Certificate of identity Refugee travel document National ID card with photo

Identity document number: _____

Issuing country: _____

Date of issue:

Date of expiry:

A2 Applicant: name as shown in identity document

Family name _____

Given name: _____

Title: Mr Mrs Ms Miss Dr Other (specify) _____

A3 Gender Male Female

A4 Date of birth

A5 Country of birth _____

A6 Contact address: _____

and/or personal email address: _____

A7 Which visa category are you applying for a visa under:

Temporary

- Visitor
- Student
- Worker with job offer
- Worker without job offer

Residence

- Skilled/Business
- Pacific Categories
- Family
- Humanitarian UNHCR
- Humanitarian other

Work to Residence

- Worker
- Family of a worker

A8 If you are applying under the Temporary – Worker with a job offer, Residence – Skilled/Business or Work to Residence – Worker categories detail your intended occupation:

A9 How long do you intend to stay in New Zealand:

- Less than 6 months 6 – 12 months 12 – 24 months More than 24 months

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.

- B1** Have you ever been diagnosed with Tuberculosis (TB)? Have you ever had to take treatment for TB? No Yes *Give details* _____
- B2** Have you ever been in close contact at home with a person known to have TB? No Yes *Give details* _____
- B3** Have you ever had prolonged medical treatment and/or repeated hospital admissions for any reason, including a major operation or psychiatric illness? No Yes *Give details* _____
- B4** Do you suffer, or have you ever suffered, from a psychological or psychiatric disorder (including major depression, bipolar disorder or schizophrenia)? No Yes *Give details* _____
- B5** Have you ever had an abnormal or reactive HIV blood test? No Yes *Give details* _____
- B6** Have you ever had an abnormal or reactive Hepatitis B or Hepatitis C blood test? No Yes *Give details* _____
- B7** Do you have or have you had cancer or malignancy in the last 5 years? No Yes *Give details* _____
- B8** Do you have diabetes? No Yes *Give details* _____
- B9** Do you have a heart condition including coronary disease, hypertension, valve or congenital disease? No Yes *Give details* _____
- B10** Do you have a blood condition (including thalassemia)? No Yes *Give details* _____
- B11** Do you have bladder or kidney problems? No Yes *Give details* _____

- B12** 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
 Yes *Give details*
- B13** Do you have an addiction to drugs or alcohol?
 No
 Yes *Give details*
- B14** Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the-counter medication and natural supplements)?
 No
 Yes

Give details of duration, dose, quantity and frequency
- B15** Do you have a hereditary or autoimmune condition?
 No
 Yes *Give details*
- B16** Do you have a neurological condition, including having had a stroke or multiple sclerosis?
 No
 Yes *Give details*
- B17** Do you have any significant family health history?
 No
 Yes *Give details*
- B18** Are you pregnant? What is the expected date of delivery?
 No
 Yes *Give details*

Examining physician:

- 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).

Physician's comments (if any)

Section C 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 Immigration New Zealand ("INZ"), Ministry of Business, Innovation and Employment ("MBIE") to determine whether or not they are satisfied that I meet the health criteria for a New Zealand visa(s);
- INZ may enter and store my personal details and health information into the eMedical system;
- INZ is authorised to collect and use my personal information under the Immigration Act 2009, regulations made under that Act and in accordance with the Privacy Act 1993; further information about the purposes for which INZ requires my information is included in my visa application form which can be found on the INZ website at www.immigration.govt.nz;
- if I have provided any false or misleading information as part of my immigration health examination, 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 INZ 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;
- INZ 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, bio details and photographs) may be disclosed to:

- New Zealand Government health agencies, health and settlement service providers and examining physician(s);
- New Zealand Government agencies entitled to receive this information by law, to the extent necessary to make decisions about my immigration status; and
- New Zealand law enforcement, health agencies and international agencies, including overseas recipients in the United Kingdom, the United States of America, Canada and Australia. [Note: if I am applying for a visa as a refugee or protected person, INZ will only disclose this information to another country, if it is satisfied that this information will not be disclosed to the country from which I have sought refugee or protection status and the disclosure is otherwise permitted under the Immigration Act 2009].

I consent to:

- INZ retaining my medical information, including any x-ray images, beyond the determination of my visa application, for the purposes of considering future applications I may make for a visa to New Zealand;
- my medical information being temporarily stored on the eMedical system owned and operated by the Australian Department of Home Affairs;
- INZ disclosing my personal information, including information about my health, to the radiologists or panel physicians who have examined me. The reason(s) for this disclosure will be to investigate inconsistencies between the radiologist and/or panel physician's examination and a previous/subsequent health assessment, to investigate a complaint against the radiologist or panel physician, or to follow up adverse results with the radiologist or panel physician to ensure the quality of the work undertaken by New Zealand's panel physician network;
- INZ storing my photograph(s) digitally and using them for client identification purposes in addition to the health examination process where INZ deems it necessary;
- INZ 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 INZ, to the extent necessary to make decisions about my immigration status;
- myself, my partner and my children undertaking a full medical examination as requested by the medical agency assigned by the Refugee Quota Branch of INZ, if I have been selected under New Zealand's Refugee Quota Programme;
- any New Zealand health service agency providing information about my state of health to INZ; and
- INZ disclosing my medical information in accordance with the provisions above.

I undertake to pay the fees for this medical examination including 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 INZ in respect of the immigration application.

Signature of person being examined _____ Date

D	D	M	M	Y	Y	Y	Y
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Signature of parent or guardian if person being examined is under 18 years of age

_____ Date

D	D	M	M	Y	Y	Y	Y
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Full name of parent or guardian (if applicable)

Relationship to person being examined (if applicable)

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 _____ Date

D	D	M	M	Y	Y	Y	Y
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(if applicable)

Full name of person assisting _____

Declaration of examining physician

Signature of examining physician _____ Date

D	D	M	M	Y	Y	Y	Y
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Full name of examining physician _____