

## Grenada – Citizenship by Investment

An application to become a citizen of Grenada under the Grenada Citizenship by Investment Programme, pursuant to Section 5 of the Grenada Citizenship by Investment Act, 2013 (Act 15).

## Medical - Form 4

**Guidance**: The medical health certification must be completed by a registered medical practitioner and signed by a licensed physician or physician's assistant authorized by law to perform medical examinations without supervision.

One medical health certification is required for each person (including children) who will be applying.

The medical practitioner must certify that he or she knows the identity of the person either through past personal or professional relationship, or by examining identification documents sufficient to satisfy the practitioner of the identity of the subject of the examination.

| Part A: Personal Details               |  |
|--|--|
| A1. Full surname, as per passport      | A2. Full first and middle names, as per passport |
|  |  |
| <b>A3</b> . Place and country of birth | A4. Date of birth (DD/MM/YYYY)                   |
|  |  |
| A5. Gender                             | A6. Passport number                              |
| Male Female                            |  |
| A7. Passport issued by                 | A8. Passport expiry date                         |
|  |  |
|  |  |

**Guidance**: The medical examiner must ask the following questions and mark the answers given. If the answer to any question is yes, then details must be provided including medical diagnosis and dates.

| <b>A9</b> . Do you currently have any serious health problems or issues?  |     |    |
|---|-----|----|
|   | Yes | No |
| <b>A10</b> . Have you visited a doctor within the past three years other than for routine check-ups?                                    |     |    |
|   | Yes | No |
| <b>A11</b> . Have you been admitted to a hospital or other medical care facility for treatment or diagnosis within the past five years? | Yes | No |
| <b>A12</b> . Do you suffer from tuberculosis, hepatitis, typhoid, or any other communicable disease?                                    | Yes | No |



| <b>A13.</b> Have you been diagnosed as having HIV, HTLV, AIDS, an AIDS related condition, or any immune deficiency syndrome?     |                             |     |    |
|--|-----------------------------|-----|----|
|  |                             | Yes | No |
| A14. Do you suffer or have you ever suffered from any nervous or mental illness or disorder?                                     |                             |     |    |
|  |                             | Yes | No |
| <b>A15</b> . Height (in cm)  | <b>A16</b> . Weight (in kg) |     |    |
| A17. Is your vision impaired and not corrected?  |                             |     |    |
|  |                             | Yes | No |
| <b>A18</b> . Cardiovascular – Any abnormalities, or signs thereof (including relating to blood pressure, pulse or heart murmurs) |                             | V   | N  |
|  |                             | Yes | No |
| <b>A19</b> . Digestive system and abdomen – Any abnormalities, or signs thereof?   |                             | Yes | No |
| <b>A20</b> . Musculoskeletal system – Any abnormalities, or signs thereof?   |                             | Yes | No |
| <b>A21</b> . Endocrine system – Any abnormalities, or signs thereof?   |                             | Yes | No |
| A22. Nervous system and sense organs – Any abnormalities, or signs thereof?  |                             | Yes | No |
| <b>A23</b> . General health and other systems – Any abnormalities, or signs thereof?   |                             | Yes | No |
| <b>A24</b> . Skin, nails, and hair – Any abnormalities, or signs thereof?  |                             | Yes | No |



| <b>A25</b> . Comments and final evaluation  |                          |  |
|---|--------------------------|--|
| A26. NOTE: Medical examiner must review the results of an HIV/AIDS test that correctly identifies this applicant and that was performed within three (3) months of the examination. Please check NO only if the test was unambiguously negative, and check YES otherwise, with remarks in the comments and evaluation section or on a separate sheet. |                          |  |
| Part B: Details of Medical Examiner   |                          |  |
| <b>B1</b> . Full name   | <b>B2</b> . Organization |  |
| <ul><li><b>B3</b>. Position</li><li><b>B5</b>. Practitioner license number or certification (if applicable)</li></ul>   | <b>B4</b> . Address      |  |
| <b>b3</b> . Tractitioner incense number of certification (in applicable)  |                          |  |
| <b>B6</b> . Telephone number  | <b>B7</b> . Fax number   |  |
| <b>Medical Examiner Certificate</b><br>I hereby certify that I have identified, questioned, and examined the applicant and have answered all of the questions and supplied all of the information to the best of my knowledge and in good faith.  |                          |  |
| Medical examiner signature and stamp:   |                          |  |
| Place of examination  | Date of examination      |  |