Malta Permanent Residence Programme

FORM MPRP 3

Medical Report and Questionnaire

RESIDENCY MALTA
AGENCY

Residency Malta Agency, Zentrum Business Centre, Level 2,
Mdina Road, Qormi, QRM 9010, Malta

customercare.residencymalta@gov.mt

Please read the document list, checklist and guidelines prior to completion of this form

Please type in your response. Handwritten forms will not be accepted. Use blue ink only for signatures, tick boxes and strikethroughs.

The Medical Report and Questionnaire is to be completed by both the applicant and the examining physician. One form for each person (including Dependants) is to be completed. In the case of a minor Dependant, this Form is to be completed by the parent/legal guardian. Please supply additional details on a separate sheet if necessary, quoting the respective Section.

The examining physician must ask for evidence of photographic identification and certify a copy of this document to be herewith attached.

Please note that, at any point in time, Residency Malta Agency maintains the right to request that Main Applicant/ Dependant attends health checks and any medical tests, which may be deemed necessary, in Malta or as directed.

Part A

A1. Full legal name and surname	
A2. Gender ☐ Male ☐ Female ☐ Other	**A3. Identification document number** (ID/Passport)
A4. Name of your licenced medical doctor (in full)	
A5. Address of your licenced medical doctor (in full)	
A6. For how many years has the medical doctor indicated in A4 been your personal doctor?	
A7. If your examining physician is not the same as your medical practitioner, please provide name of examining physician (in full)	
A8. If your examining physician is not the same as your medical doctor, please provide address of examining physician (in full)	

Part B – Additional information

The questions in this section are to be answered by the Main Applicant, or in the case of a minor Dependant, by the parent or legal guardian. If any of the questions in this section are answered "Yes" please provide dates and details of the condition(s) in B6.

B1. Have you had, or do you presently have, any of the following conditions:

Tuberculosis	☐ Yes	☐ No	AIDS / HIV & Other STDs	☐ Yes	☐ No
Hepatitis and other conditions affecting the liver	☐ Yes	☐ No	Depression, anxiety (or other psychological disorder)	☐ Yes	☐ No
Typhoid	☐ Yes	☐ No	Any immune deficiency disease	☐ Yes	☐ No
Other communicable disease	☐ Yes	☐ No	Malignancy	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Bladder / kidney problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
Blood disorder / diseases	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Other heart condition (including congenital defects)	☐ Yes	☐ No	Congenital diseases, disorders and abnormalities	☐ Yes	☐ No

B2. Do you currently have any other serious health problems? ☐ Yes ☐ No

B3. Have you been hospitalised in the last 5 years? ☐ Yes ☐ No

B4. Have you visited a doctor in the last 5 years other than for routine check-ups including for gynaecological purposes? If yes, please specify for which medical condition?

☐ Yes ☐ No

_____

B5. Are you dependent upon any drugs (prescribed or otherwise) or alcohol? ☐ Yes ☐ No

B6. Further information in relation to any questions and answered as "Yes" and/or additional medical information that you consider may be relevant

Please continue on a separate sheet and attach it to this form, if necessary, quoting section B6

☐ Please tick here if there is more information on an attached sheet

Part C - Declarations and Signatures

I declare that:

- I agree to the examining physician contacting my medical practitioner and other medical practitioners and consultants, to discuss and seek further information about any medical condition(s) that may relate to my health assessment as part of my application, and to access my medical records;
- I agree to attend health checks and any medical tests which may be deemed necessary, in Malta or as directed, should I be requested, at any point in time;
- I am aware that my medical information is required in connection with the application for a residence certificate under the Malta Permanent Residence Programme Regulations, and hereby give my consent for the processing of my health data contained in this form, by Residency Malta Agency as well as by the public health authorities of Malta as required in accordance with the laws of Malta. I also give my consent to the examining physician to disclose my health data for the purposes of my MPRP Application.

General Data Protection Regulation EU 2016/679 (GDPR) Declaration

I, _____ *(name)* of

_____ *(address line 1)*

_____ *(address line 2)*

_____ *(District)* _____ *(Province)* _____ *(State)*

_____ *(City)* _____ *(Post Code)* _____ *(Country)*

confirm that I have read and fully understood the contents of the attached Form MPRP 10 - General Data Protection Regulation EU 2016/679 (GDPR) Declaration Form and declare that I consent to my personal data being processed under the grounds and for the purposes of my application for a certificate in terms of the Malta Permanent Residence Programme Regulations, S.L. 217.26 as subject to the contents of the said Form MPRP 10, that I am in agreement with the said contents, and that I have consciously signed the said Form MPRP 10 in the appropriate section in acceptance thereof.

Name: _____

Signature: _____

Date: _____

I have read and understood all the requirements in this Form and that information supplied on or with this Form, on any attachments, whether supplied directly by myself or through a third party completing the Form on my behalf, are true, correct and up-to-date in every detail. I understand that if I supply false or inaccurate information, or omit information requested in this Form, my application will be refused, even if this is found at a later stage.

Signature of Main Applicant / Dependant	**Date of signature**

If this form has been completed by/on behalf of a Dependant below the age of 18, a parent or legal guardian must authorise and sign on his/her behalf:

Full name	**Relationship to Dependant**
Signature	**Date of signature**

Part D - Physician Examination

The examining physician is required to examine the Main Applicant/Dependant generally and to answer the following questions. Give dates and details (either in the space provided or on attached sheets) if any of the questions D3 – D11 are answered with a "Yes"

D1. Weight (in kg)	**D2. Height** (in cm)

D3. Skin – are there any signs of skin disease?	☐ Yes	☐ No
D4. Respiratory system – are there any signs of abnormalities, including nose and lungs?	☐ Yes	☐ No
D5. Cardiovascular system – are there any signs of abnormalities, including pulse, blood pressure, heart murmurs?	☐ Yes	☐ No
D6. Digestive organs and abdomen – are there any signs of abnormalities?	☐ Yes	☐ No
D7. Urogenital organs – are there any signs of abnormalities?	☐ Yes	☐ No
D8. Nervous system and sense organs – are there any signs of abnormalities?	☐ Yes	☐ No
D9. Musculoskeletal system – are there any signs of abnormalities?	☐ Yes	☐ No
D10. Endocrine system – are there any signs of abnormalities?	☐ Yes	☐ No
D11. Various – are there any signs of abnormalities?	☐ Yes	☐ No

D12. Contagious disease declaration

I certify that the person I have examined is free from any contagious disease

☐ Yes ☐ No – please specify in section D14

D13. Declaration of the examining physician

I certify that the applicant is not suffering from any other serious health condition or disease

☐ Yes ☐ No – please specify in section D14

D14. Final evaluation (continue on an attached sheet if necessary, quoting section D14)

☐ Please tick here if there is more information on an attached sheet

D15. Please specify how long has the applicant been your patient prior to this medical examination.

Part E - Examining physician details and declaration

E1. Full name of examining physician
E2. Medical registration number
E3. Full address
E4. Organisation
E5. Position
E6. Telephone number
E7. Email address

Declaration by examining physician

I declare that:

- I am in a position to assess the applicant and have been given access to all relevant medical information and records concerning the applicant.
- I have examined the medical condition of this applicant and have answered all questions in good faith and to the best of my professional knowledge and ability.
- I have attached relevant medical documents presented to me in the course of examining the health condition of the applicant.
- I declare that I have examined the applicant for any disease or condition which are considered in this form.
- I have verified the identity of the person whose details appear on this form and who presented me with the following government-issued photographic evidence of identity. A photocopy of the said document, as certified by me, is attached herewith. Please tick as appropriate:

☐ A valid passport ☐ A valid national or other government-issued identity card ☐ A valid driving licence

Signature	**Date of signature**
Official stamp	