



Malta Residence and Visa Programme FORM MRVP 3

Medical Report and Questionnaire



RESIDENCY MALTA
A G E N C Y

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

customercare.residencymalta@gov.mt

Please refer to the document list, checklist and guidelines prior to completing this form

Please use a blue ball pen to sign this form

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, the Residency Malta Agency maintains the right to request the Main Applicant/Dependant to attend for 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS / HIV & Other STDs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis and other conditions affecting the liver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression, anxiety (or other psychological disorder)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Typhoid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any immune deficiency disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other communicable disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malignancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bladder / kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood disorder / diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other heart condition (including congenital defects)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Congenital diseases, disorders and abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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 Residence and Visa Programme Regulations, and hereby give my consent for the processing of my health data contained in this form, by the 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 MRVP Application.

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

I [*name*] of [*address*] confirm that I have read and fully understood the contents of the attached Form MRVP10 - 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 Residence and Visa Programme Regulations, S.L. 217.18 as subject to the contents of the said Form MRVP10, that I am in agreement with the said contents, and that I have consciously signed the said Form MRVP 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

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”

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):

<input type="checkbox"/> A valid passport <input type="checkbox"/> A valid national or other government-issued identity card <input type="checkbox"/> A valid driving licence

Signature	Date of signature
Official stamp	