NZIS 1007
AUGUST 2005

MEDICAL & CHEST X-RAY CERTIFICATE AUGUST 2005

FOR NZIS USE

Application number	
Client number	
Date received	/ /

Immigration New Zealand TE RATONGA MANENE

Department of Labour TE TARI MAHI

SECTION A: GENERAL INFORMATION AND PERSONAL DETAILS

Who can complete this certificate?

In countries where Immigration New Zealand 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.immigration.govt.nz 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 New Zealand.

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 3 months after the medical examiner has signed the declaration. Immigration New Zealand 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 3 months or more in the last 5 years.

A12 State your occupation and the types of activities you will be performing during your intended work or course of study in New Zealand?
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? No ☐ Yes ☐ >
e.g. depression, anxiety, schizophrenia, bipolar or eating disorder?

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? No ☐ Yes ☐ >
e.g. Huntington's chorea, hyperlipidaemia, muscular dystrophies, cystic fibrosis.

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 you 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 New Zealand 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 New Zealand 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 New Zealand to provide information about my state of health to any New Zealand health service agency.
- I authorise any New Zealand health service agency to provide information about my state of health to Immigration New Zealand.
- 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 New Zealand 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 New Zealand, 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 ACT

- 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 New Zealand, have the rights provided under the Privacy Act 1993 to access personal information about you held by the Immigration New Zealand, and to ask for any of it to be corrected if you think that is necessary.
- The main recipient of the information is Immigration New Zealand, a service of the Department of Labour, but the information may also be shared with other government agencies which are lawfully entitled to it. The address of Immigration New Zealand is PO Box 3705, Wellington, New Zealand.
- The collection of the information is authorised by the Immigration Act 1987 and the Immigration Regulations made under the Act. 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:
  - New Zealand diplomatic and consular offices.
  - Any of our Immigration New Zealand branch offices.
  - The Immigration New Zealand website at **www.immigration.govt.nz**

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**

- Any signs of abnormalities (including cranial nerves, sensation, power, tone, reflexes and muscle wasting) No ☐ Yes ☐ >
- 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 5 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

Milestone	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	15 months
No 2 – 3 word phrases	36 months or more	21 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** No ☐ Yes ☐ >
(including gait and deformities of joints or limbs)

D11 **Lymph nodes** No ☐ Yes ☐ >

D12 **Endocrine system** No ☐ Yes ☐ >

D13 **Disorders of skin and scalp** No ☐ Yes ☐ >
(including scars, sores and ulcers as well as skin cancers and eczema)

D14 **Genito-urinary system** No ☐ Yes ☐ >
(consider E1 urinalysis)

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 6 months). No ☐ Yes ☐ >

D16 **General appearance** Normal ☐ Abnormal ☐ >
(including anaemia and jaundice)

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 5 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 5 years of age).
- A child under 5 years of age should have urinalysis if clinically indicated eg. 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			
Hepatitis C	Negative ☐	Positive ☐ >	
Fasting lipids	Normal ☐	Abnormal ☐ >	
Fasting glucose	Normal ☐	Abnormal ☐ >	
HBA1c	Normal ☐	Abnormal ☐ >	
Creatinine/MicroAlbumin	Normal ☐	Abnormal ☐ >	
Faeces cultures	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 New Zealand 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 New Zealand 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 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 New Zealand to contact you about this examination? No ☐ Yes ☐

LABORATORY REFERRAL FORM

NZIS 1007

Immigration New Zealand TE RATONGA MANENE

Department of Labour TE TARI MAHI

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

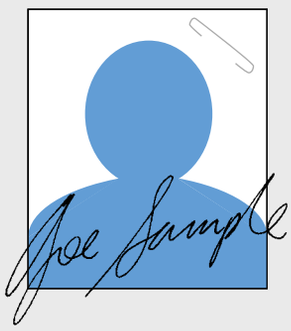
H9 Postal address

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

Ensure both sides of this form are complete.

CHEST X-RAY SECTION

Immigration New Zealand TE RATONGA MANENE

Department of Labour TE TARI MAHI

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 New Zealand practitioners

L5 Place of examination (city/state and country)

L6 Postal address

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

L8 Email address

Ensure both sides of this form are complete.