



CAYMAN ISLANDS CUSTOMS AND BORDER CONTROL ACT

APPLICATION FOR A STUDENT VISA

An application for the grant of a Student Visa should be sent to Director of Customs and Border Control, Customs and Border Control Services, P.O Box 898, Grand Cayman KY1-1103, CAYMAN ISLANDS. AN INCOMPLETE APPLICATION WILL NOT BE PROCESSED AND WILL BE RETURNED TO THE SENDER.

NOTES: (i) This form should be completed by all persons wishing to enter the Cayman Islands for the purpose of study. Please ensure that you have read the accompanying information sheet before completing this form. (ii) The form must be completed fully (even if the answer is in the negative) and in BLOCK LETTERS. An incomplete or illegible application will not be processed and will be returned to the applicant.

APPLICATION FORM CONTAINS 3 PAGES

1. Surname (Last Name) _____ Maiden Name _____ Given Names (First Names) _____

2. Nationality _____ Place of Birth _____ Date of Birth _____ Sex: Male Female

3. Marital Status Single Married Divorced Widowed Separated

4. Passport number _____ Place of Issue _____ Date Issued _____ Expiry Date _____

5. Mailing address: _____
PO Box _____ District/City _____ Country _____ Postal Code _____

(i). Physical address: _____
House/Apartment # _____ Street Name _____ District/City _____ Country _____

(ii) Telephone (Landline): _____ (iii) Telephone (Mobile): _____ (iv) Email Address: _____

6. Why do you wish to study in the Cayman Islands? _____

7. Name of educational establishment where you wish to study _____

8. Have you been accepted by this educational establishment? Yes No

9. Title of proposed course of study _____

(i) Duration of proposed course of study _____ (ii) How many hours of classroom study per week will you be required to undertake? _____

(iii) When does the course begin? _____ (iv) When does the course end? _____

10. How long do you propose to remain in the Cayman Islands? _____

11. Do you intend to leave the Cayman Islands at the end of the period of study? Yes No

12. Do you wish to be accompanied by dependant(s) whilst studying in the Cayman Islands? Yes No

If so, please provide details:

Name	Date of Birth D/M/Y	Nationality	Relationship	Country of Residence
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



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13. Please provide details of how your study and stay in the Islands is being funded? _____

14. Have you or any of your dependants accompanying you ever been convicted of a crime or sentenced to any term of imprisonment? Yes No

If Yes, please provide details:

15. Do you or any of your dependants accompanying you suffer from any disease or infirmity of mind and body? Yes No

If Yes, please provide details:

16. Where will you and any accompanying dependant(s) reside whilst in the Cayman Islands? _____

17. How much does this accommodation cost per month (including utilities)? _____

18. Dates and addresses of all places where you have lived for more than 6 months during the past 10 years, if other than stated in your reply to question 5a?

From	To	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Please provide the details the the last educational institution you attended.

From	To	Course/Qualification	Name of Institution	Address of Institution
_____	_____	_____	_____	_____

20. Are you a native English speaker? Yes No

DECLARATION

I declare the information contained in this application to be correct to the best of my knowledge and belief and am aware that it is a criminal offence to make a statement or representation that is false in a material particular which I know to be false or do not believe to be true.

Signature of prospective student _____

Date _____



STUDENT VISA - CHECKLIST

This list is a summary of general requirements for ALL applicants. The Visa Office reserves the right to request additional information or documentation as it sees fit.

APPLICANT REQUIREMENTS:

- Application form** duly completed, signed and dated by the prospective student - original signature required. **Please do not leave any question blank. If a question does not apply to you, insert "not applicable" or "n/a" in the space provided.**
- Correct **fee**
- 1 full face passport sized **photograph** **AND** 1 profile passport sized **photograph** (See online guidelines)
- Evidence of Financial resources (see online guidelines)
- Written confirmation from the educational establishment:
 - Confirming that the applicant has been accepted as a student
 - Details of the proposed course of study, its duration and the number of hours per week in attendance
 - Details of the fees per year
- If sponsored by an individual, evidence of sponsor's employment or source of income
- Original **Medical Declaration Cover Letter**.
- Original signed and sealed, **Police Clearance certificate** - less than 6 months old, from last place of residence. (If you are a British citizen and you have been resident in the UK for the last six months we will accept an original notarized affidavit of character attesting to your criminal history).

DEPENDANT REQUIREMENTS:

- Application form** duly completed, signed and dated by the prospective student or current holder of a valid student visa - original signature required. **Please do not leave any question blank. If a question does not apply to you, insert "not applicable" or "n/a" in the space provided.**
- Correct **fee**
- 1 full face passport sized **photograph** **AND** 1 profile passport sized **photograph** (See online guidelines)
- Evidence of financial resources (other than for course tuition)
- Evidence of relation to student (Birth Certificate, Marriage Certificate)
- Original Medical Declaration Cover Letter, if over 18 years of age
- Original signed and sealed, **Police Clearance certificate**, if over 18 years of age - less than 6 months old, from last place of residence. (If you are a British citizen and you have been resident in the UK for the last six months we will accept an original notarized affidavit of character attesting to your criminal history).

IMPORTANT NOTICE: As a data controller, Customs and Border Control (CBC) complies with the Data Protection Act. The personal data provided in this form will be used to determine any application for the examined individual to live and/or study in the Cayman Islands. We may verify the information that has been provided, including contacting you directly if we have any questions about this application. Visit www.gov.ky/cbc/ for our full privacy notice.



MEDICAL DECLARATION COVER LETTER

(TO BE SUBMITTED TO CUSTOMS AND BORDER CONTROL)

Date
D D M M Y Y Y Y

Reference No. (if known)

Part 1: To be completed by the applicant

First Name Last Name

Date of Birth
D D M M Y Y Y Y Country of Birth

Contact:
Cell Home Email

Sponsor*

School Name**

Purpose of Medical:

- | | |
|---|--|
| <input type="checkbox"/> Student Visa | <input type="checkbox"/> Permission - Dependant of a Caymanian |
| <input type="checkbox"/> Student Visa Dependant | <input type="checkbox"/> Extension - Dependant of a Caymanian |

*Sponsor is the first and last name of the Caymanian Family member in the case of Dependant of Caymanian Applications.

**School Name is the name of the Educational Institution in the case of Student Visa Applications.

Please do not leave any section blank. If a section does not apply to you, insert “not applicable” or “n/a” in the space provided.

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MEDICAL DECLARATION COVER LETTER

(TO BE SUBMITTED TO CUSTOMS AND BORDER CONTROL)

Part 2: To be completed by the Medical Examiner

Dear Sir/Madam,

This is to certify that I have examined on
Full Name DD MM YYYY

The applicant is of good health not of good health and does not suffer does suffer

from any/a form of communicable or mental disease that would make that person a danger to the community.

Sincerely,

First Name Last Name

Medical Registration Number

Job Title

Place of Medical Examination

E-Mail Address Phone No

I hereby declare that I am a duly appointed and or certified medical examiner. I confirm that the Information and representations contained in this Medical Examination Form (CBC/MSS001(2024/06) are true and correct to the best of my knowledge and belief. I am aware that it is a criminal offence under the Cayman Islands Customs and Border Control Act to make a statement or representation that is false or misleading and that I may be prosecuted if found in breach of this offence.

Signature of Authorizing Physician or Medical Examiner

Official Stamp



MEDICAL EXAMINATIONSFORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

1. The Medical examinations are valid for one (1) year.
2. Chest Xrays are valid for five (5) years.
3. Medical practitioners are advised to perform any tests that might be desirable depending on the disease prevalence in the respective countries.
4. The Medical Examinations Form must be signed, stamped, or sealed and retained by the medical examiner.
5. The Cayman Islands Customs and Border Control Service reserves the right to require additional medical examinations at any time.

Part 1: QUESTIONNAIRE (to be completed by the applicant)

First Name	<input type="text"/>	Last Name	<input type="text"/>
Maiden Name	<input type="text"/>	Nationality	<input type="text"/>
Passport No.	<input type="text"/>	Country of Birth	<input type="text"/>
Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y	Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Contact	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Cell	Home	Email
Physical Address	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Apt#	Bldg Name	House# Street Name
Mailing Address	<input type="text"/>	<input type="text"/>	
	District	Neighborhood	
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	P.O.Box	Postal Code	Post Office

Note: As a data controller, Customs and Border Control (CBC) complies with the Data Protection Act. The personal data provided in this form will be used to determine any application for the examined individual to live and/or study in the Cayman Islands. We may verify the information that has been provided, including contacting you directly if we have any questions about this medical examination. Visit www.gov.ky/cbc/ for our full privacy notice.



MEDICAL EXAMINATIONSFORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

Have you ever had or currently have (Choose all applicable)*

	YES	NO		YES	NO
a. Nervous or mental trouble?	<input type="checkbox"/>	<input type="checkbox"/>	g. Eye trouble?	<input type="checkbox"/>	<input type="checkbox"/>
b. Fits or convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	h. Any seriousoperation?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart trouble or raised blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	i. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
d. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	j. Any illness or injury not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
e. Cancer or othermalignancy?	<input type="checkbox"/>	<input type="checkbox"/>	k. Family history of mental trouble, suicide, fits, any kind of tuberculosis, diabetes or raised bloodpressure?	<input type="checkbox"/>	<input type="checkbox"/>
f. A sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>			

*If you have answered Yes to any of these, please explain

Do you consume alcohol? YES NO

*If Yes, how many alcoholic drinks do you typically consume in 1 week

Do you take habit-forming drugs, including opiates, benzodiazepines, and prescription medications? YES NO

*If Yes, please explain

Have you ever applied for or received disability benefits? YES NO

*If Yes, please explain

Are you now in good health? YES NO

*If No, please explain

Are you now pregnant? YES NO NOT APPLICABLE

*If Yes, how many months

Applicant printed name

Date

Signature

Medical Examiner printed name

Date

Signature



MEDICAL EXAMINATIONSFORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

Part 2: MEDICAL EXAMINATION (to be completed by Medical Examiner)

Is the Examinee personally known to you?	YES NO	<input type="checkbox"/>	<input type="checkbox"/>	If No, did you check ID?	YES NO	<input type="checkbox"/>	<input type="checkbox"/>
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Height (ft/in)	<input type="text"/>	Weight (lbs. in under clothes)	<input type="text"/>	Body massindex	<input type="text"/>
Peak flow rate	<input type="text"/>	Date and report of last E.C.G. if any	<input type="text"/>		
Blood pressure	<input type="text"/>	Pulse rate	<input type="text"/>		

Are the following free from any pathological condition or abnormality (Choose all applicable)*

a. Skin	YES NO	<input type="checkbox"/>	<input type="checkbox"/>	e. Nose	YES NO	<input type="checkbox"/>	<input type="checkbox"/>	i. Locomotor System	YES NO	<input type="checkbox"/>	<input type="checkbox"/>
b. Throat & Mouth	<input type="checkbox"/>	<input type="checkbox"/>	f. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	j. Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	g. Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	k. Genito-Urinary System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Ears	<input type="checkbox"/>	<input type="checkbox"/>	h. Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>						

*If No to any of the above questions, provide details

Is the applicant taking any medications at present or within the last six (6) months?	YES NO	<input type="checkbox"/>	<input type="checkbox"/>	*If Yes, please explain	<input type="text"/>
					<input type="text"/>

Give details of any operations

Medical conditions	a. <input type="text"/>	b. <input type="text"/>
	c. <input type="text"/>	d. <input type="text"/>

Medical Examiner printed name	Date of Examination	Signature
<input type="text"/>	<input type="text"/>	<input type="text"/>

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MEDICAL EXAMINATIONSFORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

Part 3: XRAY AND LABORATORY INVESTIGATIONS (to be completed by Medical Examiner)

Hospital XrayNo	<input type="text"/>	Date	<input type="text"/>	Results	<input type="text"/>
Urine: Date	<input type="text"/>	Albumin	<input type="text"/>	Sugar	<input type="text"/>
Blood Tests:	SYPHILIS	Date	<input type="text"/>	Results	<input type="text"/>
	HIV SCREEN	Date	<input type="text"/>	Results	<input type="text"/>

Medical Examiner

First Name Last Name

Medical Registration Number

Qualifications

Address of Registering Body

Mailing Address

P.O.Box Postal Code Post Office

E-Mail Address

Date of Examination	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Signature	<input type="text"/>
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Note: A medical examination before arrival in the Cayman Islands may only be completed by a practitioner fully registered as a medical doctor by the medical councils of either the United Kingdom, United States, Canada, or the Cayman Islands. If a medical examination cannot be undertaken by a practitioner who is registered in one of these countries, CBC may offer a temporary condition to allow the person to enter, however, he/she must have a medical examination completed in the Cayman Islands, by a medical doctor registered in the Cayman Islands, and the medical declaration cover letter must be submitted to satisfy application requirements.