

**WORK PERMIT**  
**OTHER PARTICULARS TO BE SUPPLIED WITH RESIDENCE/WORK APPLICATION**  
**FORM (L.I. 12)**

All non-Nationals above the age of 18 years **MUST** complete application form **IN DUPLICATE.**

Applications **MUST** in addition supply the following particulars with this form:

- (1) A medical certificate that the applicant is in good health and has not in the past three years suffered from any communicable disease (***Form attached***)
- (2) Letter from employer stating the following: type of employment, wages (daily, weekly, monthly); accepting responsibility for employee; and offer of employment for one year in the first instance
- (3) A statement from the Commissioner of Police of the applicant's **HOME STATE** setting out the applicant's police record
- (4) Proof that the applicant has a return ticket to his normal place of residence or has made a deposit to cover the cost of such ticket
- (5) Two (2) passport-size photographs
- (6) Application fee: **\$800.00 (Non-CARICOM Members)** OR **\$250.00 (CARCOM)**
- (7) Photocopy of Treasury receipt as proof of payment of application fee
- (8) Marriage Certificate
- (9) Two testimonials one of which shall be from the last employer
- (10) Three copies of newspaper clippings of advertised vacant position
- (11) Valid passports (***passports must be valid up to six months at any given time***)
- (12) Extension of stay is required until permit is approved
- (13) Photo copy of passport bio-data page.
- (14) If self employed please include
  - I. A Bank Statement
  - II. Certificate of Registration

THE IMMIGRATION AND PASSPORT ACT, CHAP. 18:01 OF 1990  
APPLICATION FOR PERMIT TO RESIDE/WORK IN DOMINICA

NAME OF APPLICANT (IN FULL): \_\_\_\_\_

AGE: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

CHILDREN: \_\_\_\_\_

NAMES AND AGES OF CHILDREN BELOW THE AGE OF 18 YEARS ACCOMPANYING YOU:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PRESENT ADDRESS: \_\_\_\_\_

CONTACT TELEPHONE NO(S): \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NATIONALITY: \_\_\_\_\_ AT BIRTH IF DIFFERENT: \_\_\_\_\_

DATE AND PLACE OF BIRTH: \_\_\_\_\_

PASSPORT NO.: \_\_\_\_\_ PLACE OF ISSUE: \_\_\_\_\_

DATE OF ISSUE: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

POLICE RECORD: \_\_\_\_\_

REASONS FOR WISHING TO SETTLE HERE: \_\_\_\_\_

HAVE YOU BEEN OFFERED EMPLOYMENT?: \_\_\_\_\_

NAME OF FIRM OR AGENCY MAKING OFFER: \_\_\_\_\_

HAVE YOU ANY SPECIAL SKILLS OR TRAINING?: \_\_\_\_\_

PROFESSIONAL OR OTHER QUALIFICATIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

COPIES OF PROFESSIONAL CERTIFICATES, ETC.: \_\_\_\_\_

DEPOSIT FOR PASSAGE: \_\_\_\_\_ CAN YOU MEET THIS?: \_\_\_\_\_ RETURN TICKET: \_\_\_\_\_

STATE NO. OF PREVIOUS PERMIT: \_\_\_\_\_

RECEIPT NO. FOR APPLICATION FEE: \_\_\_\_\_

SCHEDULED DATE OF ARRIVAL: \_\_\_\_\_

EXTENSION OF STAY VALID UNTIL: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

<b>MEDICAL EXAMINATION OF APPLICANTS FOR RESIDENCE/WORK PERMIT</b>		Place																		
		Date of Examination																		
At the request of the Ministry of Labour Dominica		City	Country																	
I certify on the above date I examined	Name		Age																	
	Who bears passport No.		Sex																	
		Issued By	On																	
<p>I examined specifically for evidence of any of the following conditions:</p> <p><u>CLASS A:</u></p> <p style="margin-left: 40px;">DANGEROUS CONTAGIOUS DISEASES:</p> <table style="width: 100%; margin-left: 40px;"> <tr> <td style="width: 50%;">Chancroid</td> <td style="width: 50%;">Lymphogranuloma</td> </tr> <tr> <td>Gonorrhoea</td> <td>Syphilis, infectious stage</td> </tr> <tr> <td>Granuloma inguinale</td> <td>Tuberculosis, active</td> </tr> <tr> <td>Leprosy, infectious</td> <td>HIV</td> </tr> </table> <p style="margin-left: 40px;">MENTAL CONDITIONS:</p> <table style="width: 100%; margin-left: 40px;"> <tr> <td style="width: 33%;">Mental retardation (mental deficiency)</td> <td style="width: 33%;">Previous occurrence of one or more attacks of insanity</td> <td style="width: 33%;">Mental defect</td> </tr> <tr> <td>Insanity</td> <td>Psychopathic personality</td> <td>Narcotic drug addiction</td> </tr> <tr> <td></td> <td>Sexual deviation</td> <td>Chronic alcoholism</td> </tr> </table> <p><u>CLASS B:</u></p> <p style="margin-left: 40px;">Physical Defect, Disease, or Disability serious in degree or permanent in nature amounting to a substantial departure from normal physical well-being.</p> <p><u>CLASS C:</u></p> <p style="margin-left: 40px;">Minor Conditions</p>				Chancroid	Lymphogranuloma	Gonorrhoea	Syphilis, infectious stage	Granuloma inguinale	Tuberculosis, active	Leprosy, infectious	HIV	Mental retardation (mental deficiency)	Previous occurrence of one or more attacks of insanity	Mental defect	Insanity	Psychopathic personality	Narcotic drug addiction		Sexual deviation	Chronic alcoholism
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<p>(CHECK NUMBER (1) BELOW OR COMPLETE NUMBER (2))</p> <p>My examination, including the X-ray and other reports below, revealed:</p> <p>◀(1) No defect, disease, or disability.</p> <p>(2) Defect, disease, or disability, or previous occurrence of one or more attacks of insanity, as follows (give class — A, B, or C — diagnosis, and permit details*):</p>																				
<p>Chest X-ray report.....</p> <p>.....</p> <p>.....</p> <p style="text-align: right;">..... From Dr. ....</p> <p>Blood serological report ..... From Dr. ....</p> <p>Other special report(s) when needed .....</p> <p style="text-align: right;">..... From Dr. ....</p>																				
Signature of Medical Technical Advisor		TITLE	DATE OF FINAL REPORT																	

\*Continue on reverse side if necessary