# APPLICATION FOR STUDY, RESEARCH, OR LECTURING IN THE UNITED STATES AND FOR A FELLOWSHIP, SCHOLARSHIP.) ASSISTANTSHIP OR OTHER EDUCATION GRANT

Having been selected to receive a Fulbright/or other U.S. Department of State educational exchange grant, the submission of a completed Medical History and Examination Form is a required part of the grant process. The attached form should be completed and returned to the Fulbright Commission or the Public Affairs Section of the U.S. Embassy in your country.

You should complete the Medical History portion of the form (Part I - Items 1 - 11) prior to the medical examination. The Physical Examination Form (Part II) must be completed by a qualified, licensed physician.

You should contact the Fulbright Commission/Foundation, U.S. Embassy, or AID Mission for a list of approved English speaking physicians.

Before you complete the Medical History Questionnaire, please note:

THE U.S. DEPARTMENT OF STATE (DOS) DOES NOT PROVIDE MEDICAL INSURANCE FOR DEPENDENTS WHO ACCOMPANY GRANTEES. GRANTEES SHOULD PURCHASE PRIVATE MEDICAL INSURANCE FOR DEPENDENTS.

DOS MEDICAL INSURANCE DOES NOT COVER TREATMENT FOR A MEDICAL CONDITION FOR WHICH TREATMENT HAS BEEN RENDERED OR RECOMMENDED PRIOR TO THE EFFECTIVE DATE OF ENROLLMENT IN THE DEPARTMENT'S INSURANCE PROGRAM.

DOS MEDICAL INSURANCE COVERS ONLY THE GRANT PERIOD AND APPROVED EXTENSIONS. EXCHANGE PARTICIPANTS WHO REMAIN IN THE U.S. AFTER EXPIRATION OF THESE PERIODS FOR ADDITIONAL WEEKS OR MONTHS SHOULD CONTINUE COVERAGE AT THEIR OWN EXPENSE.

# MEDICAL HISTORY AND EXAMINATION FORM

**FOREIGN GRANTEES FOR STUDY, RESEARCH, LECTURE, EDUCATIONAL AND CULTURAL EXCHANGE GRANTS**

## I. MEDICAL HISTORY

**Medical History must be completed by applicant in English and signed before visiting the examining physician**. Please type or print in ink.

**1**. NAME _____
(Last First Other)

**2.** DATE OF BIRTH _____ **3**. SEX _____ Male _____ Female
(month/day/year)

**4**. CITY & COUNTRY OF ORIGIN _____
or CITY & COUNTRY OF PERMANENT RESIDENCE

**5**. PRESENT ADDRESS _____
(Home or Residence City Country)

**6.** LOCATION OF GRANT _____ 7. DATES _____
(If known) (University City/State) (From To)

**8. Indicate "YES" or "NO." "YES" answers MUST be explained in space provided (additional space available on reverse side of this form.)**

| | YES | NO | EXPLANATION |
|---|---|---|---|
| a. Have you ever had any significant or serious illness(es) or injuries? (State nature of problems/place/dates) | | | |
| b. Have you ever had any operations or been advised by a physician to have an operation? (Describe and give place/dates) | | | |
| c. Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give place/dates) | | | |
| d. Do you currently take medication for treatment of a medical condition (list name/dose) or do you require the use of a medical device? | | | |

**9. Do you now have or have you ever had any of the conditions listed below? (Check "YES" or "NO" for each item)**

| (CHECK EACH ITEM) | YES | NO | (CHECK EACH ITEM) | YES | NO |
|---|---|---|---|---|---|
| a. Epilepsy, convulsions, "fits" | | | m. Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.) | | |
| b. Eye disease, vision defect in one or both eyes | | | | | |
| c. Tooth or gum disease (periodontal disease) | | | n. Depression, anxiety, attempted suicide or other psychological symptoms | | |
| d. Asthma, emphysema, or other lung conditions | | | | | |
| e. Tuberculosis or exposure to tuberculosis | | | o. Drug o narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives | | |
| f. High/low blood pressure, heart disease | | | | | |
| g. Stomach, liver (hepatitis), gallbladder disease | | | p. Bleeding disorder, blood disease, sickle cell anemia | | |
| h. Hernia (rupture)/Genito-Urinary/Rectal Disorder | | | | | |
| i. Kidney or bladder condition, stone or blood | | | q. Tumor, abnormal growth, cyst, or cancer | | |
| j. Diabetes, sugar in the urine | | | r. Skin disorder, growths, psoriasis | | |
| k. Joint disease or injury, swollen or painful joints | | | s. Gynecological disease/abnormal menses | | |
| 1. Back pain, or spinal condition, use of back brace | | | t. Hearing impairment | | |

**10. If you answered "YES" to any item in Part 9, explain in detail, include dates of occurrence, treatment, and outcome:**

_____

_____

**ADDITIONAL SPACE FOR REPLYING TO ITEMS 8 AND 10:**

11. Name two individuals who could be notified in case of emergency (one in the U.S., one in your home country)

Name _____ Relationship
Address _____
Telephone number(s) _____
Name _____ Relationship
Address _____
Telephone number(s) _____

12. 1 certify that I have reviewed the foregoing information supplied by me, and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the grant activity, I authorize release of my medical records to the U.S. Department of State or its designated contractual agency.

I understand that if any of this information is found to be substantially inaccurate of incomplete, it may be grounds for termination of my grant and my return home.

Signature _____ Date _____

## II. PHYSICAL EXAMINATION FORM

This physical examination form must be completed in English by a licensed and qualified physician after reviewing the examinee's medical history (Part I), conducting a physical examination, and assessing laboratory and X-Ray results. The examining physician must comment an all positive and/or significant findings and sign where indicated. Please type or print in ink

1. APPLICANT'S NAME _____
(Last First Other)

**2**. HEIGHT _____ **3**. WEIGHT _____ **4**. CORRECTED VISION 20: _____ 20: _____
(in or cm) (l lb or kg) L R

**5**. BLOOD PRESSURE _____ **6**. PULSE RATE _____
(sysi./diast.) (Circle whether regular or irregular)

**7**. URINALYSIS _____
(sugar) (albumin) (microscopic examination)

**8**. ELECTROCARDIOGRAM REPORT (if indicated by history or physical examination)

_____

_____

_____

**9.** BLOOD SEROLOGY TEST FOR SYPHILIS/Test Used _____ pos neg _____

**10**. A skin test for tuberculosis is required of all applicants. The PPD skin test is measured and if the reaction is 15 mm or greater, a chest X-Ray is required to assist in the diagnosis of active tuberculosis if present.

Tuberculin Skin Test: PPD Test: _____ mm

BCG Vaccine: No ____ Yes ____ Date Given _____

Date and Result of Chest X-Ray: _____

**11. CLINICAL EVALUATION:** (Please provide an answer to each item; abnormal findings must be fully explained in space provided.)

| NORMAL | | ABNORMAL | DESCRIBE ABNORMAL FINDINGS |
|---|---|---|---|
| | Head, Nose, Mouth | | |
| | Ears, Hearing Acuity | | |
| | Eyes, Visual Acuity | | |
| | Lungs and Chest/Breast | | |
| | Heart, Rhythm and sounds | | |
| | Vascular System | | |
| | Abdomen, Hernia, etc. | | |
| | Rectum/Prostate Hemorrhoids Fistuia | | |
| | Urinary System | | |
| | Spine and Extremities | | |
| | Skin, Lymph Nodes, Scars | | |
| | Neurological System/Reflexes | | |
| | Emotional Stability | | |

12. THE PHYSICIAN MUST COMMENT ON ALL ITEMS MARKED "YES" IN THE HISTORY (PART 1) AND COMMENT ON ANY CONDITION DISCOVERED DURING THE EXAMINATION.

_____

_____

_____

13. PHYSICIAN'S SUMMARY STATEMENT AND DIAGNOSIS:

_____

_____

_____

14. IMMUNIZATION REQUIREMENTS The applicant is responsible for obtaining immunizations required by host institutions for entry into the United States. The WHO International Certificate of Vaccination is the proper document for recording immunizations or vaccinations. Universities require proof of immunization against the following diseases:

**MEASLES (Rubeola)**
Date of Live Immunization: _____

or Date of Disease: _____

**RUBELLA**
Date of Immunization: _____

or Date of Rubella Titer: _____

**POLIO**
Date series completed, type: _____

**MUMPS**
Date of Immunization: _____

**DIPHTHERIA (DPT), Whooping Cough, Tetanus**

Date Series Completed: _____

**TETANUS BOOSTER**
(Most Recent): _____

**NOTE:** HISTORY OF DISEASE IS ACCEPTABLE PROOF OF IMMUNITY TO RUBELLA.
RESULTS

I have completed my physical examination to the best of my knowledge and have reviewed the applicant's medical history, laboratory evaluations, tuberculin skin tests, and immunization record. I certify that the applicant is free of active tuberculosis, syphilis, and other sexually transmitted or contagious diseases.

It is my opinion that the applicant's physical and emotional condition is satisfactory for full course study, research, or lecturing in an academic environment and that there are no limitations on activity or special assistance expected for the duration of the grant period proposed.

YES_____ NO_____

_____ _____
Signature Printed Name of Physician

_____ _____ _____
Date Country Where Licensed Number

_____

_____
Address of Physician

## FOR REVIEWING AUTHORITY USE ONLY:

The applicants history, physical examination results, and examining physician's opinion have been reviewed **and are found** to be (complete/incomplete) and (meet the standards/do not meet the standards) for the proposed academic grant.

REVIEWED BY_____

SIGNATURE _____

ORGANIZATION _____

DATE_____