FULBRIGHT PROGRAM

APPLICATION FOR STUDY IN THE UNITED STATES
AND FOR A FELLOWSHIP, SCHOLARSHIP, ASSISTANTSHIP OR OTHER EDUCATIONAL GRANT

MEDICAL HISTORY AND EXAMINATION FORM INSTRUCTIONS

Having been selected to receive a Fulbright grant, you are required to submit a completed *Medical History and Examination Form*. The attached form should be completed and returned to the Fulbright Commission or Public Affairs Section of the US Embassy in your country.

You should complete the *Medical History* portion of the form (Part I—Items 1 to 10) prior to the medical examination. The *Physical Examination Form* (Part II—Items 1 to 14) must be completed by a qualified, licensed physician.

The US Embassy, Fulbright Commission/Foundation, or AID Mission may be able to provide you with a list of English speaking physicians.

Before you complete the *Medical History* questionnaire, please note:

THE US DEPARTMENT OF STATE DOES NOT PROVIDE MEDICAL INSURANCE FOR DEPENDENTS WHO ACCOMPANY GRANTEES. GRANTEES SHOULD PURCHASE PRIVATE MEDICAL INSURANCE FOR DEPENDENTS.

US DEPARTMENT OF STATE 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 AGENCY'S INSURANCE PROGRAM.

US DEPARTMENT OF STATE 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

I. MEDICAL HISTORY

MEDICAL HISTORY MUST BE COMPLETED BY THE 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: _____
Month/Day/Year

3. SEX: ☐ Male ☐ Female

4. PLACE OF ORIGIN OR PERMANENT RESIDENCE: _____
City *Country*

5. PRESENT ADDRESS: _____
Home or Residence *City* *Country*

6. GRANT LOCATION: _____
(If known) *University/City/State*

7. DATES: _____
From *To*

8. Indicate "YES" or "NO". "YES" answers MUST be explained in the space provided. (Additional space available on Page 2 of this form.)

	YES	NO	EXPLANATION
(a) Have you ever had any significant or serious illness(es) or injuries? (State nature of problems/places/dates.)			
(b) Have you ever had any operations or been advised by a physician to have an operation? (Describe and give places/dates.)			
(c) Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give places/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		YES	NO
(a) Epilepsy, convulsions, fits.			(k) Joint disease or injury, swollen or painful joints.		
(b) Eye disease, vision defect in one or both eyes.			(l) Back pain, or spinal condition, use of back brace.		
(c) Tooth or gum disease (periodontal disease).			(m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.).		
(d) Asthma, emphysema, or other lung conditions.			(n) Depression, anxiety, attempted suicide or other psychological symptoms.		
(e) Tuberculosis or exposure to tuberculosis.			(o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives.		
(f) High/low blood pressure, heart disease.			(p) Bleeding disorder, blood disease, sickle cell anemia.		
(g) Stomach, liver (hepatitis), gallbladder disease.			(q) Tumor, abnormal growth, cyst, or cancer.		
(h) Hernia (rupture)/Genito-Urinary/Rectal Disorder.			(r) Skin disorder growths psoriasis.		
(i) Kidney or bladder condition, stone or blood.			(s) Gynecological disease/abnormal menses.		
(j) Diabetes, sugar in the urine.			(t) Hearing impairment.		

10. If you answered "YES" to any item in Question 9, please explain in detail (include dates of occurrence, treatment, and outcome):

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Questions 8 and/or 10 (Continued):

11. Name two individuals who could be notified in case of emergency (one in the United States and one in your home country).

Name:		Name:	
Address:		Address:	
Telephone number(s)		Telephone number(s)	
E-mail address(es)		E-mail address(es)	
Relationship:		Relationship:	

12. I 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 or incomplete, it may be grounds for termination of my grant and my return home.

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY AND EXAMINATION FORM

II. PHYSICAL EXAMINATION FORM

THIS PHYSICAL EXAMINATION FORM MUST BE COMPLETED IN ENGLISH BY A DESIGNATED 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 ON 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: _____ *in or cm*

3. WEIGHT: _____ *lb or kg*

4. CORRECTED VISION: 20:_____ *Left* 20: _____ *Right*

5. BLOOD PRESSURE: _____ *syst./diast.*

6. PULSE RATE:_____ *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 UNLESS A BCG VACCINATION HAS BEEN GIVEN RECENTLY. If vaccinated and a PPD skin test is contraindicated, a chest X-Ray is required to rule out active tuberculosis.

Tuberculin Skin Test: PPD Test: _____ ☐ Pos ☐ Neg

BCG Vaccine Given: ☐ No ☐ Yes Date of Series: _____

Date and Result of Chest X-Ray: _____

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

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
(a) Head, Nose, Mouth.			
(b) Ears, Hearing Acuity.			
(c) Eyes, Visual Acuity.			
(d) Lungs and Chest/Breast.			
(e) Heart, Rhythm and sounds.			
(f) Vascular System.			
(g) Abdomen, Hernia, etc.			
(h) Rectum/Prostate, Hemorrhoids, Fistula.			
(i) Urinary System.			
(j) Spine and Extremities.			
(k) Skin, Lymph Nodes, Scars.			
(l) Neurological System/Reflexes.			
(m) Emotional Stability.			

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

13. PHYSICIAN'S SUMMARY STATEMENT AND DIAGNOSIS:

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14. IMMUNIZATION REQUIREMENTS

The applicant is responsible for obtaining the required immunizations 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: _____

NOTE: HISTORY OF DISEASE IS NOT ACCEPTABLE PROOF OF IMMUNITY TO RUBELLA.

RESULTS: _____

POLIO

Date series completed, type: _____

MUMPS

Date of Immunization: _____

DIPHTHERIA (DPT), Whooping Cough, Tetanus

Date series completed: _____

TETANUS BOOSTER (Most Recent): _____

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, and any other contagious diseases.

It is my opinion that the applicant's physical and emotional condition is satisfactory for a full course of 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: _____ NAME OF PHYSICIAN (printed): _____

DATE: _____ COUNTRY WHERE LICENSED: _____ NUMBER: _____

ADDRESS OF PHYSICIAN: _____

FOR REVIEWING AUTHORITY USE ONLY:

The applicant's 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: _____ DATE: _____

SIGNATURE: _____

ORGANIZATION: _____