

# 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

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)	_____
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. information Agency 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: \_\_\_\_\_ 3. WEIGHT: \_\_\_\_\_ 4. CORRECTED VISION: 20: \_\_\_\_\_ 20: \_\_\_\_\_  
*in or cm*
*lb or kg*
*Left*
*Right*

5. BLOOD PRESSURE: \_\_\_\_\_ 6. PULSE RATE: \_\_\_\_\_  
*syst./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 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:  
 \_\_\_\_\_  
 \_\_\_\_\_

# MEDICAL HISTORY AND EXAMINATION FORM

## 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: \_\_\_\_\_

### 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 NOT 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, 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: \_\_\_\_\_