

**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, 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 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.

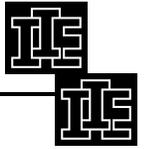
The Embassy, Fulbright Commission/Foundation, or AID Mission may be able to provide you with a list of English speaking physicians.

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

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

THE UNITED STATES 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.

THE UNITED STATES 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.



**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*

<b>Name:</b>							
<i>Last</i>		<i>First</i>		<i>Other</i>			
<b>2. DATE OF BIRTH:</b> (Day/Month/Year)			<b>3. SEX:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female				
<b>4. PLACE OF ORIGIN OR PERMANENT RESIDENCE:</b>							
<i>City</i>			<i>County</i>				
<b>5. PRESENT ADDRESS:</b> <input type="checkbox"/> <input type="checkbox"/>							
<i>Home or Residence</i>		<i>City</i>		<i>Country</i>			
<b>6. GRANT LOCATION:</b>			<b>7. DATES:</b>				
<i>(If known)</i> _____ <i>University/City/State</i>			_____ <i>From</i> _____ <i>To</i>				
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.)	<input type="checkbox"/>	<input type="checkbox"/>					
b) Have you ever had any operations or been advised by a physician to have an operation? (Describe and give	<input type="checkbox"/>	<input type="checkbox"/>					
c) Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give places/dates.)	<input type="checkbox"/>	<input type="checkbox"/>					
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?	<input type="checkbox"/>	<input type="checkbox"/>					
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.	<input type="checkbox"/>	<input type="checkbox"/>		m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
b) Eye disease, vision defect in one or both eyes.	<input type="checkbox"/>	<input type="checkbox"/>		n) Depression, anxiety, attempted suicide or other psychological symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	
c) Tooth or gum disease (periodontal disease).	<input type="checkbox"/>	<input type="checkbox"/>		o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives.	<input type="checkbox"/>	<input type="checkbox"/>	
d) Asthma, emphysema, or other lung conditions.	<input type="checkbox"/>	<input type="checkbox"/>		p) Bleeding disorder. blood disease, sickle cell anemia.	<input type="checkbox"/>	<input type="checkbox"/>	
e) Tuberculosis or exposure to tuberculosis.	<input type="checkbox"/>	<input type="checkbox"/>		q) Tumor, abnormal growth, cyst, or cancer.	<input type="checkbox"/>	<input type="checkbox"/>	
f) High/low blood pressure, heart disease.	<input type="checkbox"/>	<input type="checkbox"/>		r) Skin disorder growths psoriasis.	<input type="checkbox"/>	<input type="checkbox"/>	
g) Stomach, liver (hepatitis), gallbladder disease.	<input type="checkbox"/>	<input type="checkbox"/>		s) Gynecological disease/abnormal menses.	<input type="checkbox"/>	<input type="checkbox"/>	
h) Hernia (rupture)/Genito-Urinary/Rectal Disorder.	<input type="checkbox"/>	<input type="checkbox"/>		t) Hearing impairment.	<input type="checkbox"/>	<input type="checkbox"/>	
i) Kidney or bladder condition, stone or blood.	<input type="checkbox"/>	<input type="checkbox"/>					
j) Diabetes, sugar in the urine.	<input type="checkbox"/>	<input type="checkbox"/>					
k) Joint disease or injury, swollen or painful joints.	<input type="checkbox"/>	<input type="checkbox"/>					
l) Back pain, or spinal condition, use of back brace.	<input type="checkbox"/>	<input type="checkbox"/>					
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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11. Name two individuals who could be notified in case of an 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 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: \_\_\_\_\_

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**MEDICAL HISTORY AND EXAMINATION FORM**

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## 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. APPLICANTS 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**

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.	<input type="checkbox"/>	<input type="checkbox"/>	
b) Ears, Hearing Acuity.	<input type="checkbox"/>	<input type="checkbox"/>	
c) Eyes, Visual Acuity.	<input type="checkbox"/>	<input type="checkbox"/>	
d) Lungs and Chest/Breast.	<input type="checkbox"/>	<input type="checkbox"/>	
e) Heart, Rhythm and Sounds.	<input type="checkbox"/>	<input type="checkbox"/>	
f) Vascular System.	<input type="checkbox"/>	<input type="checkbox"/>	
g) Abdomen, Hernia, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
h) Rectum/Prostate, Hemorrhoids, Fistula.	<input type="checkbox"/>	<input type="checkbox"/>	
i) Urinary System.	<input type="checkbox"/>	<input type="checkbox"/>	
j) Spine and Extremities.	<input type="checkbox"/>	<input type="checkbox"/>	
k) Skin, Lymph Nodes, Scars.	<input type="checkbox"/>	<input type="checkbox"/>	
l) Neurological System/Reflexes.	<input type="checkbox"/>	<input type="checkbox"/>	
m) Emotional Stability.	<input type="checkbox"/>	<input type="checkbox"/>	

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:

**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. Generally, universities require proof of immunization against the following disease:

**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): \_\_\_\_\_

\*Please check with the hosting university to ascertain if other immunizations are required

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:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **COUNTRY WHERE LICENSED:** \_\_\_\_\_ **NUMBER:** \_\_\_\_\_

**ADDRESS OF PHYSICIAN:** \_\_\_\_\_

*PLEASE RETURN DIRECTLY TO THE STUDENT IN A SEALED ENVELOPE UNLESS OTHERWISE INSTRUCTED.*

**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: \_\_\_\_\_