



PHYSICIAN CERTIFICATION

*To be completed and signed by a licensed physician. PLEASE PRINT CLEARLY.
Please list immunizations on this form rather than attaching additional sheets of paper.*

This form is intended to certify that your patient, _____, is medically able to participate in the American Jewish World Service ("AJWS") program described below ("Program"). As part of the Program, your patient may travel to and visit an extremely rural area with only rudimentary sanitary facilities. The conditions your patient will face will be physically and mentally demanding. Please complete this certification in order to help us determine your patient's ability to participate in the Program.

BRIEF DESCRIPTION OF PROGRAM:

Participants in AJWS Volunteer Corps serve for two to twelve months on volunteer assignments with local NGOs in developing countries such as India, Thailand, Cambodia, Ghana, Uganda, Kenya, Mexico, El Salvador, Nicaragua, Honduras and Guatemala. Projects require volunteers to live and work in local communities in both rural and urban environments. Volunteers are often subjected to extreme heat and may have to walk or bike to their work assignments. Volunteers travel using public transportation and may have to travel long distances for program orientations, retreats, and for work related meetings and conferences.

To be completed by physician/practitioner:

HEALTH HISTORY:

Please check the boxes next to each of the conditions your patient has had in his/her health history:

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Rheumatic Fever
- Substance abuse
- Alcohol abuse
- Mental illness
- Social or behavioral disorders

IMMUNIZATION HISTORY/DATES (DO NOT attach a separate page)

Please check the box next to each of the immunizations your patient has had and indicate the date (mm/yy) of immunization:

- DPT _____
- Polio OPV (Sabin) _____
- MMR _____
- Smallpox _____
- Tetanus Booster _____
- Hepatitis A _____
- Hepatitis B _____
- TB Mantoux Test (date of last test and result) _____
- Meningitis _____

- Chicken Pox _____
- Pertussis _____
- Diphtheria _____
- Yellow Fever _____
- Typhoid _____

PATIENT'S EMERGENCY MEDICAL NEEDS:

Does your patient wear a medical alert bracelet, or may patient otherwise require emergency medical care because of an underlying medical condition? If so, please explain nature of patient's medical condition, any health restrictions associated with that condition, and the type of emergency care that your patient may require:

Does your patient have diabetes? If so, are his/her activities restricted in any way? If so, please explain:

Does your patient's blood type or other condition make patient less amenable to transfusion? Please explain.

Does your patient have any underlying or pre-existing medical conditions that may call for emergency medical treatment and/or that AJWS or emergency care practitioners should be aware of (including in case your patient is unable to communicate for him/herself)? _____

Is your patient currently under the care of a psychiatrist or psychologist (if yes, please provide name and address)?

Is your patient currently suffering from mental health, social, or behavioral illnesses or disorders (or does your patient have a history of any such illnesses or disorders) that would impact his/her ability to participate successfully in the Program or in a group or social environment (if so, please explain):

PATIENT'S KNOWN ALLERGIES (please include allergies to medications):

PATIENT'S MEDICATIONS/RESTRICTIONS:

Your patient is on the following medications (please describe dosage, time of day taken, reason, and any other instructions): _____

Your patient has discontinued the following medications in the last six months (please describe dosage, reason for discontinuation, and any other pertinent information): _____

Please identify and explain any recommended restrictions to your patient's activities: _____

OTHER PERTINENT INFORMATION/COMMENTS:

Please provide any additional information you believe would be of interest.

CERTIFICATION:

I have examined this individual and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in the Program described above, except as otherwise noted.

Signature of Examining Physician

Date

Print Name

Address

Telephone Number