PHYSICIAN CERTIFICATION

_____ [print full name of program participant/ patient] has advised me that s/he wishes to participate in international travel with AJWS. I understand that s/he will be traveling to: _____ [country] for _____ [duration]

I have been advised that while AJWS seeks to include all participants, regardless of physical ability or medical condition, AJWS is limited by the infrastructure and services available in the communities they visit and that medical services and treatment in the country of travel may not be of the same quality as is available in the United States.

In my professional opinion, _____ [print full name of program participant/ patient]

- ☐ IS NOT medically fit to fully and safely participate in this international travel.
- ☐ IS medically fit to fully and safely participate in this international travel.
- ☐ IS medically fit to fully and safely participate in this international travel, subject only to the following special requirements or accommodations (please list if applicable):

  _____

  _____

  _____

_____

Physician Name

_____

Physician Signature

_____

Physician Phone Number

_____

Physician Address

_____

Physician City, State, Zip