Adventist Volunteer Health Clearance

Adventist Volunteer Service
www.AdventistVolunteers.org

Dear Volunteer, A Physician, PA or Nurse Practitioner must complete this Adventist Volunteer Health Clearance form. Spouses should submit a separate form. Each volunteer is responsible to meet any required immunizations there are for the country they will be serving in. (http://www.cdc.gov/)

☐ I agree to this form being shared with relevant organizations who may consider my application.

Applicant Name (Please Print) _____ Applicant Signature (Required) _____ Date of Birth (Day/Month/Year) _____

Dear Medical Provider:

Please note that the patient may be located in a remote and isolated international area for 6 to 12 months where there is limited provision for medical treatment or renewal of prescriptions. The assignment could be physically and emotionally demanding. Incorporate these considerations into your review. (Use reverse side if needed)

Please indicate if patient:

1. Has experienced a medical problem in the past or is currently undergoing treatment for heart attack, heart surgery, cancer, etc. (if yes, please explain) ☐ Yes ☐ No
   _____
2. Has ever been treated or is currently receiving treatment for mental illness, nervous breakdown, depression, emotional or eating disorder, etc. (if yes, please explain) ☐ Yes ☐ No
   _____
3. Has ever been treated or is currently receiving treatment for substance abuse (example: illegal drugs, prescription medication, alcohol, etc.) (if yes, please explain) ☐ Yes ☐ No
   _____
4. Is currently receiving treatment for high blood pressure ☐ Yes ☐ No
5. Is currently receiving treatment for diabetes ☐ Yes ☐ No
6. Has a condition requiring immediate access to medical services or facilities (if yes, please explain) ☐ Yes ☐ No
   _____
7. Has allergies: environmental, medication or food (if yes, please explain) ☐ Yes ☐ No
   _____
8. Has asthma ☐ Yes ☐ No
9. Has a condition which limits physical activities (if yes, please explain) ☐ Yes ☐ No
   _____
10. Has any learning disabilities such as dyslexia (if yes, please explain & circle one: Mild / Moderate / Severe) ☐ Yes ☐ No
    _____
11. Is currently taking prescription medication (if yes, please explain) ☐ Yes ☐ No
    _____
12. Has any other reason why he/she should not be able to serve as a volunteer/ student missionary? (if yes, or if with conditions, please explain) ☐ Yes ☐ No
    _____

Physician Asst or Nurse Practitioner (circle one) (please print) _____ Signature _____ Phone Number (include country & city code) _____ Email Address _____

Physician (please print) _____ Signature _____ License No. of Physician _____ Date (Day/Month/Year) _____