MEDICAL REPORT for ECOLOGY ACTION INTERN APPLICANTS

This report must be completed by a licensed doctor who has examined the applicant to the internship program and knows his/her medical history.

Please upload your completed form as a single document (PDF or JPEG) to your application form.

Name of the Patient: _____ Height: _____Weight: _____Sex: **M/ F**

Date of the examination:_____/_____/_____ Examination location (city): _____

Name of Doctor: _____License number:_____

Doctor's Contact Information:_____

_____

1) How long have you known the patient? _____

2) Does the patient or any close relative have a contagious disease? **Yes /No**
If you answered yes, please describe:

_____

_____

3) Does the patient have any history of serious injury, illness or disease? **Yes /No**
If the answer is yes, please describe the condition, duration of the treatment, age of the patient at the time of treatment, and final result of the treatment:

_____

_____

_____

4) Please test the patient for tuberculosis. Did this patient test □ **Negative** or □ **Positive** for TB?

5) Is the patient currently taking any prescription medicine or in need of ongoing medical treatment? **Yes / No**
If the answer is yes, please describe the medicine and reason for treatment:

_____

_____

6) Is the patient allergic to penicillin, other antibiotics or other medications? **Yes / No**
If yes please specify:_____

7) What year did the patient last receive a vaccination for Tetanus? _____
If longer than 5 years ago, please administer now and provide the date of the injection: ___/____/_____

8) Does the patient smoke? **Yes / No**
If the answer is yes, how many cigarettes per day? _____

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9) Does the patient drink alcoholic beverages?

□ **Never** □ **Occasionally** □ **Frequently** (more than 5 times per week)

10) Check the box if the patient has problems or previous history with any of these conditions:

□ heart disease
□ dental problems
□ gum disease
□ allergies
□ asthma
□ skin condition
□ organs
□ underweight
□ lack of mobility
□ broken/improperly healed bones
□ bleeding
□ shortness of breath
□ back problems
□ joint problems
□ diabetes
□ cancer
□ HIV+
□ sexually transmitted disease
□ ulcer
□ hearing loss
□ poor eyesight
□ nervous disorder
□ anemia
□ fatigue/lack of energy
□ appetite loss
□ drug addiction
□ alcoholism
□ obesity
□ cough
□ infection
□ depression
□ Other.

If you checked any of the boxes, please describe:

_____

_____

_____

11) This patient has applied to join a U.S. farm-training program. This program requires daily, physically rigorous activity. Is there any medical reason that might prevent the patient from performing well in such a program? **Yes / No**

If the answer is yes, please explain:

_____

_____

_____

12) Please indicate the general health of the patient: □ **Excellent** □ **Good** □ **Fair** □ **Poor**

Doctor's name: _____

Signature:_____ Date: ___/___/_____

Official Stamp: