Report of Medical Examination

MUST BE FILLED OUT BY AN EXAMINING PHYSICIAN

The following form is designed for evaluating the medical condition of applicants for the program 'Teach and Learn with Georgia". Please fill in all the fields and attach all the necessary additional documents. When attaching additional documents, please provide applicant's name on each separate page.

Name (Last, First, Middle Initial)

____

Sex M☐ F☐ **Date of Birth** _____/_______/________ **(DD / MM/ YYYY)**

Current Address:

____

____

Permanent Address (if different from current address):

____

____

Telephone Number: ____

E-mail: ____

Measurements and Other Findings

Height (cm)	**Weight** (kg)	**Blood type**	**Blood Pressure** (mm) (resting)	**Pulse** (bpm) (resting)	**Hearing** (whisper test or other gross test)	**Gross Vision** (Attach any additional existing documents)	
						Uncorrected Right 20/__ 20/__ Left 20/__	Corrected Right Left 20/__

Required Lab Tests (*Lab Reports must be attached*)

☐ HIV/AIDS serology

☐ Hepatitis B core antibody (in case positive result Hepatitis **B Surface Antigen- HBsAg)**

☐ Hepatitis C antibody

☐ Drug Test (Narcotics) [*attached form must be filled in together with lab reports*]

☐ Tuberculin Test, Mycobacterium tuberculosis IgA/IgM/IgG

Recommended Immunizations

Immunization Type	Date of Immunization
1. DPT Booster	
2. Polio Booster (after age 18)	
3. MMR Booster (one booster needed per lifetime)	
4. Hepatitis A	

Additional Questions and Comments

1. *Do you have any medical concerns about the applicant that might limit his/her assignment area (e.g. mountainous territory, humidity, etc)?*

☐ YES ☐ NO

If yes, please specify

____

____

2. *In your opinion, does the applicant have any physical condition(s) that would limit or restrict full participation in a 'Teach and Learn with Georgia' program?*

☐ YES ☐ NO

If yes, please specify

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3. *Does the applicant have any psychological condition(s) or psychological needs that would limit or restrict full participation in a 'Teach and Learn with Georgia' program?*

☐ YES ☐ NO

If yes, please specify

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Physician Signature/title ____

Date____________________ ***Physician License Number*** ________________________

Physician Address and Phone Number

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PLEASE NOTE THAT ALL THE FIELDS IN THE APPLICATION FORMS MUST BE FILLED IN FOR THE APPLICATION TO BE PROCESSED

Required Lab Tests for Drugs of Abuse (Narcotics)

(*Lab Reports must be attached*)

The form is provided for the applicant for the program 'Teach and Learn with Georgia' program and should present adequate information on the applicant's drug test (narcotics) based on the laboratory checks by a licensed physician. Please attach the lab report to this form.

As ascertained from the lab test conducted on __/______/___, (DD/MM/YYYY)

At the Hospital/clinic ____

____

____ (Facility Name and Address)

I verify that patient

___________________ _________________ ____________________

(Name) (Middle Name) (Last Name)

☐ ***Did not test positive for drug use or abuse, including but not exclusive to:***

Narcotics, Opiates, Amphetamines and Cannabis

☐ ***Lab report attached***

☐ ***Did not exhibit symptoms of alcoholism or abuse of prescription drugs***

Physician Signature/Title ____

Date__________ Physician License Number _________________________________

Physician Address and Phone Number

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