



Suite à votre sélection pour recevoir une bourse Fulbright, il vous est requis de fournir une description complète de votre passé médical et un formulaire d'examen médical. Le formulaire ci-joint doit être complété et renvoyé à la Commission Fulbright ou au Bureau des Affaires Publiques de l'Ambassade des Etats-Unis de votre pays.

Veillez remplir la partie du formulaire sur votre passé médical (Partie I) avant votre visite médicale. Le formulaire de la visite médicale (Partie II) doit être rempli par un médecin licencié et qualifié.

Avant de remplir le questionnaire sur votre passé médical, veuillez noter que:

Le Programme Fulbright n'offre pas d'assurance médicale pour les personnes à charge qui accompagnent les boursiers. Les boursiers doivent acheter une assurance médicale privée pour les personnes à charge.

L'assurance médicale du Programme Fulbright ne couvre pas les traitements des problèmes médicaux pour lesquels un traitement a déjà été effectué ou conseillé avant la date actuelle d'inscription dans le programme d'assurance d'agence.

L'assurance médicale du Programme Fulbright ne couvre que la période de la durée de la bourse et des prolongations qui ont été approuvées. Les participants au programme d'Echange qui restent aux USA pour quelques semaines ou quelques mois après la date d'expiration de leur programme doivent continuer à être couverts par une assurance à leurs propres frais.

Gardez en votre possession plusieurs copies de ce formulaire une fois rempli; et si possible, faites certifier ces copies "conformes à l'original" et apportez-les avec vous aux Etats-Unis. Nous vous conseillons de faire ces démarches, car de nombreuses universités américaines exigent que leurs nouveaux étudiants présentent des preuves d'immunisation contre certaines maladies, en particulier contre la rougeole. Si vous apportez les copies de votre certificat médical, cela peut vous éviter des dépenses supplémentaires et cela vous permettra de ne pas avoir à vous faire vacciner de nouveau ou de vous faire faire de nouvelles analyses de sang une fois arrivé à votre université.

CERTIFICATE OF HEALTH

APPLICATION FOR STUDY, RESEARCH, OR LECTURING IN THE UNITED STATES AND FOR A FELLOWSHIP, SCHOLARSHIP, ASSISTANTSHIP, OR OTHER EDUCATIONAL GRANT

PART I. TO BE COMPLETED AND SIGNED BY APPLICANT BEFORE VISITING THE PHYSICIAN.

Name of applicant (please print)	Country	Age	(Check one)
		DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female

A. Do you now have or have you, to the best of your knowledge, ever had any of the following: (check box for any "yes" answers):

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Disease of Nervous System | <input type="checkbox"/> Rectal Disease or Disorder | <input type="checkbox"/> Disease or Disorder of the Back or Spine |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies to Drugs | <input type="checkbox"/> Disease of Kidneys or Genito-Urinary System |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Disease of Eyes | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Alcohol, Drug, or Narcotic Dependency |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Disease of Ears or Hearing Loss | <input type="checkbox"/> Gynecological Disorder | <input type="checkbox"/> Mental Health Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis or Bone Disease | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Heart or Vascular Disease or Disorder | |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Disease of Skin | <input type="checkbox"/> Disease of Prostate | | |
| <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Venereal Disease | | | |
| <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Mental Disorder | | | |

Chronic or serious physical condition which might affect participation in full-time study/research program. _____

Medications currently taken by you. _____

If you have said "yes" to any of the above, give: (1) specific name of disorder; (2) duration-specify dates; (3) final results. _____

B. During the past five years, when and for what injury, illness or mental disorder (including any of the above or others), have you been under observation; had medical or surgical advice or treatment; been hospital-confined? Give: (1) specific name of disorder; (2) duration-specify dates; (3) final results (if none, write "none".) _____

C. To the best of your knowledge and belief, are you in good physical and mental health? yes no (if no, give specific name of disorder, treatment, and present condition.) _____

D. All recipients of grants or awards are required to have health insurance. One of the insurance plans used requires that a beneficiary be named. Since the plan which might apply in the individual case is not known at present, all applicants are required to name a beneficiary.

Name of beneficiary _____ Relationship to you _____

I certify that the information provided by me is complete and true and accurately reflects my health status.

Signature of applicant _____ Date _____

PART II. TO BE COMPLETED AND SIGNED BY PHYSICIAN

Insert height, weight, and blood pressure. Enter "N" if normal. Enter "AB" if abnormal and describe in detail under remarks.

Height _____ Visual Test _____ Eyes _____ Rectum _____ Chest/Breasts _____
Weight _____ Head _____ Skin _____ Pharynx _____ Abdomen/Hernia _____
Blood Pressure _____ Nose _____ Ears/Hearing _____ Reflexes _____ Heart, murmurs,
rhythm _____
Urinalysis (recommended): Albumin _____ Sugar _____ Microscopic _____

B. Comment in full on condition of applicant's lungs (indicate if there is any sign or symptoms of active tuberculosis at present) or chronic conditions that require treatment or periodic evaluation: _____

C. Has the applicant ever suffered from any nervous or mental disorders? _____

D. After reviewing the applicant's history and completing your physical examination, do you consider the applicant physically and mentally able to carry on a full course of study involving long hours of work in a college or university and to adjust to life in the United States? Yes No

E. In my opinion, the applicant's health and physical condition are: Excellent Good Fair Poor

Temperature: _____ Pulse: _____ Respirations: ____/____

Has applicant ever received a BGC vaccine? Yes No

Note: the health service requires a PPD skin test to be done on all international students unless they have had a BGC vaccine. If a student has had a BGC vaccine they must have a chest x-ray.

Has applicant ever had a PPD skin test? Yes No

Date of test ____/____/____

Results _____

Date of last chest x-ray ____/____/____

Results _____

I certify that the above applicant is free from tuberculosis.

Physician's Signature Date

Immunization requirements:

The university requires proof of immunity against measles and rubella. Clearance for registration may be delayed or withheld if this information is not complete.

Measles (rubeola)

Date of live immunization: ___/___/___

or date of disease: ___/___/___

Certified by physician signature

Rubella

Date of immunization: ___/___/___

or date of rubella titer: ___/___/___

Note: history of disease is **not** acceptable proof of immunity to rubella.

Results: _____

Polio

Date series completed: ___/___/___
Type-IPV/OPV

Mumps

Date of immunization: ___/___/___

DPT original series completed: ___/___/___

Latest tetanus or booster: ___/___/___

Certification by physician: I have reviewed the clinical history as given by the applicant.

Remarks: describe any abnormalities noted in part II–A, B, C, D, E, and add any other comments:

Signature

Date

Name and title of physician (please print)

License number

Address

FOR REVIEWING AUTHORITY USE ONLY:

The applicant's history, physical examination results, and examining physician's opinion have been reviewed and are found to be (complete/incomplete) and (meet the standards/do not meet the standards) for the proposed academic grant.

Reviewed by _____ Date _____

Signature _____

Organization _____