APPLICATION FOR TEACHING IN THE UNITED STATES

# MEDICAL HISTORY AND EXAMINATION FORM INSTRUCTIONS

The submission of a completed Medical History and Examination Form is a required part of the J-1 visa application process. The attached form should be completed and included with your J-1 visa materials.

You should complete the Medical History portion of the form (Part I Items 1 to 10) prior to the medical examination. The Physical Examination Form (Part II Items 1 to 14) must be completed by a qualified, licensed physician.

# MEDICAL HISTORY AND EXAMINATION FORM

## I. MEDICAL HISTORY

MEDICAL HISTORY MUST BE COMPLETED BY THE APPLICANT IN ENGLISH AND SIGNED BEFORE VISITING THE EXAMINING PHYSICIAN

PLEASE TYPE OR PRINT IN INK

1. NAME: ____________________________________________
   Last — First — Other

2. DATE OF BIRTH: ______________________ Month/Day/Year

3. SEX: Male Female

4. PLACE OF ORIGIN OR PERMANENT RESIDENCE: ______________________
   City — Country

5. PRESENT ADDRESS: ______________________
   Home or Residence — City — Country

6. ASSIGNMENT LOCATION: ______________________ University/City/State
   (If known)

7. DATES: ______________________
   From — To

8. Indicate YES or NO. YES answers MUST be explained In the space provided. (Additional space available on Page 2 of this form.)

| | YES | NO | EXPLANATION |
|---|---|---|---|
| (a) Have you ever had any significant or serious illness(es) or injuries? (State nature of problems/places/dates.) | | | |
| (b) Have you ever had any operations or been advised by a physician to have an operation? (Describe and give places/dates.) | | | |
| (c) Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give places/dates.) | | | |
| (d) Do you currently take medication for treatment of a medical condition (list name/dose) or do you require the use of a medical device? | | | |

9. Do you now have or have you ever had any of the conditions listed below? (Check YES or NO for each Item.)

| CHECK EACH ITEM | YES | NO | CHECK EACH ITEM | YES | NO |
|---|---|---|---|---|---|
| (a) Epilepsy, convulsions, fits. | | | (m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.). | | |
| (b) Eye disease, vision defect in one or both eyes. | | | | | |
| (c) Tooth or gum disease (periodontal disease). | | | (n) Depression, anxiety, attempted suicide or other psychological symptoms. | | |
| (d) Asthma, emphysema, or other lung conditions. | | | | | |
| (e) Tuberculosis or exposure to tuberculosis. | | | (o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives. | | |
| (f) High/low blood pressure, heart disease. | | | | | |
| (g) Stomach, liver (hepatitis), gallbladder disease. | | | (p) Bleeding disorder. blood disease, sickle cell anemia. | | |
| (h) Hernia (rupture)/Genito-Urinary/Rectal Disorder. | | | (q) Tumor, abnormal growth, cyst, or cancer. | | |
| (i) Kidney or bladder condition, stone or blood. | | | (r) Skin disorder growths psoriasis. | | |
| (j) Diabetes, sugar in the urine. | | | (s) Gynecological disease/abnormal menses. | | |
| (k) Joint disease or injury, swollen or painful joints. | | | (t) Hearing impairment. | | |
| (l) Back pain, or spinal condition, use of back brace. | | | | | |

10. If you answered YES to any item in Question 9, please explain in detail (include dates of occurrence, treatment, and outcome):

# MEDICAL HISTORY AND EXAMINATION FORM

**Questions 8 and/or 10 (Continued)**:

11. Name two individuals who could be notified in case of emergency (one in the United States and one in your home country).

Name: ____________________________________________

Address: __________________________________________

__________________________________________

Telephone number(s): ________________________________

Relationship: ______________________________________

Name: ____________________________________________

Address: __________________________________________

__________________________________________

Telephone number(s): ________________________________

Relationship: ______________________________________

12. I certify that I have reviewed the foregoing information supplied by me, and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the assignment, I authorize release of my medical records to the United States Department of State or its designated contractual agency.

I understand that if any of this information is found to be substantially inaccurate or incomplete, it may be grounds for termination of my status in the United States and my return to China.

SIGNATURE: ________________________________________ DATE: ______________________________

# MEDICAL HISTORY AND EXAMINATION FORM

## II. PHYSICAL EXAMINATION FORM

THIS PHYSICAL EXAMINATION FORM MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND QUALIFIED PHYSICIAN AFTER REVIEWING THE EXAMINEEíS MEDICAL HISTORY (PART I), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE EXAMINING PHYSICIAN MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS AND SIGN WHERE INDICATED.

PLEASE TYPE OR PRINT IN INK

1. APPLICANTíS NAME: ______________________________
   Last First Other

2. HEIGHT: ______________ in or cm

3. WEIGHT: ______________ lb or kg

4. CORRECTED VISION: 20: ____________ 20: ____________
   Left Right

5. BLOOD PRESSURE: ______________________ syst./diast.

6. PULSE RATE: ______________________ Circle whether regular or irregular

7. URINALYSIS: ______________ ______________ ______________
   Sugar Albumin Microscopic examination

8. ELECTROCARDIOGRAM REPORT (If indicated by history or physical examination):

9. BLOOD SEROLOGY TEST FOR SYPHILIS: Test Used: ______________________ Positive Negative

10. A SKIN TEST FOR TUBERCULOSIS IS REQUIRED OF ALL APPLICANTS UNLESS A BCG VACCINATION HAS BEEN GIVEN RECENTLY. If vaccinated and a PPD skin test is contraindicated, a chest X-Ray is required to rule out active tuberculosis.

    Tuberculin Skin Test: PPD Test: ______________________ Positive Negative

    BCG Vaccine Given: No Yes Date of Series: ______________________

    Date and Result of Chest X-Ray: ______________________________

11. CLINICAL EVALUATION: (Please provide an answer to each item. Abnormal findings must be fully explained in the space provided.)

| | NORMAL | ABNORMAL | DESCRIBE ABNORMAL FINDINGS |
|---|---|---|---|
| (a) Head, Nose, Mouth. | | | |
| (b) Ears, Hearing Acuity. | | | |
| (c) Eyes, Visual Acuity. | | | |
| (d) Lungs and Chest/Breast. | | | |
| (e) Heart, Rhythm and Sounds. | | | |
| (f) Vascular System. | | | |
| (g) Abdomen, Hernia, etc. | | | |
| (h) Rectum/Prostate, Hemorrhoids, Fistula. | | | |
| (i) Urinary System. | | | |
| (j) Spine and Extremities. | | | |
| (k) Skin, Lymph Nodes, Scars. | | | |
| (l) Neurological System/Reflexes. | | | |
| (m) Emotional Stability. | | | |

12. THE PHYSICIAN MUST COMMENT ON ALL ITEMS MARKED YES IN THE MEDICAL HISTORY (PART I) AND COMMENT ON ANY CONDITION DISCOVERED DURING THE EXAMINATION.

13. PHYSICIAN'S SUMMARY STATEMENT AND DIAGNOSIS:

# MEDICAL HISTORY AND EXAMINATION FORM

14. IMMUNIZATION REQUIREMENTS

The applicant is responsible for obtaining the required immunizations for entry into the United States. The WHO International Certificate of Vaccination is the proper document for recording immunizations or vaccinations. Universities require proof of immunization against the following diseases:

MEASLES (Rubeola)

Date of Live Immunization: ________________________

or Date of Disease: ______________________

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: ________________________

MUMPS

Date of Immunization: ______________________

DIPHTHERIA (DPT), Whooping Cough, Tetanus

Date series completed: ________________________

TETANUS BOOSTER (Most Recent): ________________________

I have completed my physical examination to the best of my knowledge and have reviewed the applicant's medical history, laboratory evaluations, tuberculin skin tests, and immunization record. I certify that the applicant is free of active tuberculosis, and any other contagious diseases.

It is my opinion that the applicantís physical and emotional condition is satisfactory for a full course of study, research, or lecturing in an academic environment and that there are no limitations on activity or special assistance expected for the duration of the assignment period proposed.

**YES** **NO**

SIGNATURE: ________________________________________ NAME OF PHYSICIAN (printed): ________________________________________
DATE: ____________________________ COUNTRY WHERE LICENSED: ____________________________ NUMBER: ___________________________
ADDRESS OF PHYSICIAN: ____________________________________________________________________________________________________

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: __________________________________________________________________________