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) _____