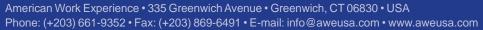
2016 Medical Summary Report





INSTRUCTIONS: As a participant on the American Work Experience programme, you are required to have a physical exam before departing for the U.S. This form must be completed and signed by a licensed physician. This form does not affect your employer's decision to hire you or determine your acceptance onto the AWE programme. However, falsifying or failing to disclose information about your health may result in immediate dismissal. If you have any questions or concerns, please contact the AWE office.

Note: Both the applicant and physician must sign this form. Please send the original form to AWE and keep a copy for your records.

IMPORTANT:

The doctor MUST place his/ her official stamp here. Alternatively, a signed business card or official letterhead must be attached.

	ARTICIPANT:			AWE #	
Name	Birthdate/	Age	□ Female □ Male	Do you smoke? ☐ Yes ☐ No	
Complete home address					
Home phone	Work phone		_ Fax		
Emergency contact name		Relationship _			
Emergency contact phone	Work phone	Fax _			
Alternate emergency contact name		Phor	ne		
List any surgery or major illnesses you h	nave had in the last 18 month	s (include dates):			
List any chronic, recurring illnesses or m	edical conditions:				
Have you ever been under a profess	ional's care for emotional	or psychological	difficulties? 🖵 Ye	es 🗆 No If yes, please describe	
Do you have any dietary restrictions?	☐ Yes ☐ No If yes, pleas	se describe:			
Do you consume alcoholic beverages:	☐ Yes ☐ No If yes, pleas	se describe:			
I hereby certify that the above info company or AWE to obtain any in					
Applicant's signature			Date		
II. TO BE COMPLETED BY THE F	PHYSICIAN:				
Illness/conditions/allergy history (p).			
☐ frequent ear infections			ma	mononucleosis	
□ heart defect/disease			fever		
□ migraine headaches			oisonings		
□ hypertension			ct stings		
□ bleeding/clotting disorder			•	bulimia	
u other	·	· · · · · · · · · · · · · · · · · · ·			
Immunization history (please prov					
DPT series (Diphtheria, Pertussis,	•	Polio	Tvp	hoid	
MMR (Mumps, Measles, Rubella) _		Smallpox		anus Booster	
Hemophilus Influenza B (HIB)				Tuberculin test	
□ Pos. □ Neg.					

Please use the other side of this form if you have any additional comments

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Please use this side for additional comments you wish to make, or to provide more details.

First Name	Last Name	AWE ID#