NGO LEADERSHIP TRANSITION FELLOWSHIP PROGRAM (LTFP)

Medical Fitness Assessment

In order to participate in the 2019 NGO Leadership Transition Fellowship Program after you have been selected, you **MUST** complete a medical fitness assessment, documented and submitted using the **three forms** provided. The assessment **MUST be carried out by a licensed medical doctor**. This assessment is to ascertain your health status before commencement of the program, to enable ARNOVA-AROCSA and host institution staff to be of full assistance to you if and when the need arises.

Instructions for completing the health assessment forms

Before going for the medical examination

- Please complete, by yourself before seeing the assessment;
- Ensure you sign and date the form (page 9)
- Read carefully and understand the instructions and tests the doctor is required to carry out shown in Forms II and III to be sure you can meet the requirements.

During the medical examination

- Ensure the doctor evaluates your health as required in Form II and Form III
- Confirm Form II and Form III are dully signed by the doctor.
- Request the doctor to give you the **completed and signed medical report and test results** early enough;

* Please note that incomplete forms or forms not duly signed will not be accepted and could lead to delay or denial of your participation in the program.

After the medical examination:

- Compile your medical report to include pages 2-8. Please include additional comments or results you deem necessary.
- Scan all the reports into **one PDF document;**
- Please make sure the scanned **document is readable**;
- Name the scanned document as: **2019 NLTF-Lastname-Firstname**
- Email the scanned document to aokaomee@arnova.org

Form I: To be completed by candidate (Please complete in CAPITAL LETTERS)

Name: _____ Last First Other	
Date of Birth: _____ (DD/MM/YYYY)	SEX: ☐ Male ☐ Female
Present Address: _____ House number / Street name. City Country	

Do you have a current health insurance that can cover you during your stay in the United States for the Fellowship program? ☐ Yes ☐ No

If yes, please complete the information below. Please note that your current health insurance indicated below will be your main insurance while in the program.

Health Insurance Provider:	
Name of Health Insurance Plan	
Health Insurance Plan ID#:	
Health Insurance Provider Address:	
Start Date of Health Plan:	
End Date of Health Plan: (if applicable)	

Medical Consultations within last three (3) years

If you have consulted a medical doctor / practitioner for issues other than routine check-ups within the **last three** years, please list their names in the space provided below. Please indicate if the physician is your primary care doctor or a specialist.

S/No	Doctor's Name	Primary doctor?	Specialist?	Telephone

Emergency Contact and Medical Proxy to be notified in case of emergency.

Please list two persons that you want to be notified in case of any emergency. Should you be unable to make a medical decision in case of a medical situation, a medical proxy - a person who knows you and can make medical decisions in your behalf will become necessary. Please name such person below and upload any legal documentation to this effect.

Emergency Contact 1	**Emergency Contact 2**	**Medical Proxy**
Name:	Name:	Name:
Address:	Address	
Phone:	Phone:	Phone:
Email:	Email:	Email:
Relationship to you:	Relationship to you:	Relationship to you:

Instructions for the Medical Doctor

The person named in Form 1 is selected to participate in a 3-month Fellowship program outside his/her home country. This examination is required for the candidate to receive the best support in case of any medical condition during the program. It is crucial you carry out a thorough investigation of everything indicated in the medical form, following the instruction below:

1. Include comments for any medical condition answered "Yes" in the Medical History form.
2. Record results of all physical examinations completed NOT more than three (6) months to candidate's arrival date.
3. Attach lab and X-ray results within six months from September 1, 2019.
4. Indicate any recommended follow-up investigations, or medical conditions requiring constant examinations.
5. Overall, state your opinion of candidate's health status (page 9)
6. Please **sign and date** the examination form you completed (page 9).

Form II: TO BE COMPLETED BY QUALIFIED MEDICAL DOCTOR

Please consult with the candidate, and complete the form below. Please include comments for any condition indicated as "Yes" and recommend any test(s) that may be required to ascertain candidate's current medical status and/or to predict what condition to be expected under specified circumstance.

CANDIDATE'S MEDICAL HISTORY			
Indicate "Yes" if candidate has had in the past or currently has the medical condition or symptom(s) below. Also include dates when condition occurred, treatments given and outcome of treatment			
Condition/ Symptom	**Yes**	**No**	**Comment if "Yes"**
Frequent or severe headaches			
Epilepsy or seizures			
Stroke			
Hearing impairment			
Tooth or gum disease (periodontal disease)			
Asthma, emphysema, persistent cough, or other lung conditions.			
Tuberculosis			
High blood pressure			
Gynecological disorder			
Other hormonal disorders, incl. thyroid			
Diabetes mellitus (high blood sugar, sugar in urine)			
Fainting spells (syncope)			

Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure			
Eye disease or vision impairment (other than corrected refractive error)			
Severe allergies, including environmental, insect stings, food, and medication			
Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.).			
Depression, anxiety, excessive worry, schizophrenia, psychosis			
Drug or alcohol abuse			
Sickle cell anemia, excessive bleeding, blood clots or other blood disorder			
Cancer in any form			
HIV infection, AIDS			
Severe skin disorder			

Form III. Physical Examination

This section is to be completed by a qualified Medical Doctor.

For all conditions below with a "Yes" response, please explain nature of condition, dates of occurrence and treatment, and explain outcome of treatment or condition.

Has candidate:

Had any previous major illness or injury **NOT** included in medical history above? If yes, please explain.
Undergone any surgical procedures that may be of concern during the program?
Ever been hospitalized for any reason? If yes, explain
Ever seen a psychiatrist/psychologist/psychotherapist? If yes, explain.
Taken any medications in last three (3)? List all medications.
Any current medications? List all (indicate whether regular or occasional).
Any medical devices being used (like breathing aids, insulin device)? List all.

Medical Examination

*** All test and x-ray results MUST NOT be more than six (6) months by date of candidate's arrival in the United States for the Fellowship program.**

MEDICAL EXAMINATION FORM			
Applicant's Name: _____ Last First Middle			
Height (inches)			
Weight (Kg)			
Blood pressure			
Heart Rate			
CLINICAL INVESTIGATION			
Condition	**Normal**	**Abnormal**	**Explain abnormal case**
Head			
Neck			
Neurologic			
Hearing			
Sight (Visual Acuity)			
Heart			
Chest / Lung			
Breasts			
Abdomen			
Muscular / Skeletal			
Skin			
Psychiatric			
Lymphatic			

Tuberculosis test

This test is required irrespective of previous vaccination for BCG. If using a PPD skin test, note that chest X-ray is required for results over 10mm. Interferon gamma release assay blood test is equally acceptable. Any abnormal results of PPD skin or Interferon gamma release assay blood tests requires a chest X-ray to confirm if tuberculosis is active

Tuberculin Skin Test (PPD) Result (millimeters of induration): _____ ☐ Pos ☐ Neg

Date of test: _____ **OR** IGRA Test Date: _____ ☐ Pos ☐ Neg

Chest X-ray (if required) Date: _____

Chest X-ray findings: _____

Please note that you do not need to submit X-ray images on film

Vaccinations

Condition	Dates of Immunization
POLIO (Three or more doses)	
Diphtheria, Pertussis, Tetanus (Three or more doses, one within the past 10 years)	
Measles – Mumps – Rubella (MMR) (Or list individual Measles, Mumps, and Rubella immunizations below)	
MEASLES Dates of Live Immunization (two required, at least one month apart) (or) date of disease occurred (or) date and results of measles titer	Date of 1st Immunization: Date of 2nd Immunization: OR Date Measles occurred: OR Date/Result of measles titer:
MUMPS Dates of Immunization (two required, at least one month apart) (or) date of disease occurred (or) date and results of mumps titer	Date of 1st Immunization: Date of 2nd Immunization: OR Date mumps occurred: OR Date/Result of mumps titer:
RUBELLA Dates of Immunization (two required, at least one month apart) (or) Indicate date and results of rubella titer *__History of disease is not proof of immunity to rubella__	Date of 1st Immunization: Date of 2nd Immunization: OR Date and result of rubella titer:

DOCTOR'S STATEMENT

From your investigation and evaluation of the candidate's medical history, physical examination and test results, would you consider the candidate physically and emotionally fit to live/study/engage in research writing in the United States for a period of three months (September – November 2019)

☐ Yes ☐ No

If you answered "No", please provide explanation:

_____ _____

Signature of Examining Medical Doctor **Date**

Name of Examining Medical Doctor _____

Telephone#: _____

Address_____

_____

CANDIDATE'S STATEMENT

I certify that information I supplied in Form I and information supplied by my physician in Form II and Form III is complete and accurate to the best of my knowledge. Should any serious medical condition/emergency arise during the Fellowship program, I authorize my medical records to be released to relevant authorities. I understand my medical records are provided to organizing agency/ host institution for purposes of medical clearance. I admit that including false or excluding critical medical information may be grounds to deny me participation in the program.

_____ _____

Signature of Candidate **Date**

Privacy Policy: Information supplied in these Forms will used for administrative purpose, shared with appropriate medical staff should the need arise.