Teach and Learn with Georgia

Report of Medical Examination

MUST BE FILLED OUT BY AN EXAMINING PHYSICIAN

The following form is designed for evaluating the medical condition of applicants for the program 'Teach and Learn with Georgia". Please fill in all the fields and attach all the necessary additional documents. When attaching additional documents, please provide applicant's name on each separate page.

Name (last, First, Middle Initial)

____

Sex M ☐ F ☐ **Date of birth** ______/________/_________ **(DY / MO/ YR)**

Current Address:

____

____

Permanent Address (If different from current address):

____

____

Telephone Number: ____

E-mail: ____

Measurements and Other Findings

Height	Weight	Blood type (group) and + or -	Blood Pressure	Pulse	Hearing	Gross Vision
						Uncorrected: Right 20/__ Left 20/__ Corrected: Right 20/__ Left 20/__
Feet/inches	lbs.		mm (resting)	bpm (resting)	Whisper test or other gross test	Attach any additional existing documents

Required Lab Tests (*Lab Reports must be attached*)

☐ HIV/AIDS serology

☐ Hepatitis B core antibody

☐ Hepatitis C antibody

☐ Drug Test (Narcotics) [*Attached form must be filled in together with lab reports*]

☐ Tuberculin Test

Required Immunizations

Immunization Type	Date of Immunization
1. Td Booster	
2. Polio Booster (after age 18)	
3. MMR Booster (one booster needed per lifetime)	

Additional Questions and Comments

1. *Do you have any medical concerns about the applicant that might limit his/her assignment area (e.g. mountainous territory, humidity, etc)?*

☐ YES ☐ NO

If yes, please specify ____

____

2. *In your opinion, does the applicant have any physical condition(s) that would limit or restrict full participation in a 'Teach and Learn with Georgia' program?*

☐ YES ☐ NO

If yes, please specify ____

____

3. *Does the applicant have any psychological condition(s) or psychological needs that would limit or restrict full participation in a 'Teach and Learn with Georgia' program?*

☐ YES ☐ NO

If yes, please specify ____

____

Physician Signature/title ____

Date_______________________ ***Physician License Number*** ______________________________

Physician Address and Phone Number ____

____

PLEASE NOTE THAT ALL THE FIELDS IN THE APPLICATION FORMS MUST BE FILLED IN FOR THE APPLICATION TO BE PROCESSED

Teach and Learn with Georgia

Required Lab Tests for Drugs of Abuse (Narcotics)

(*Lab Reports must be attached*)

The form is provided for the applicant for the program 'Teach and Learn with Georgia' program and should present adequate information on the applicant's drug test (narcotics) based on the laboratory checks by a licensed physician. Please attach the lab report to this form.

As ascertained from the lab test conducted on __/_______/____,

(Day/month/year)

At the Hospital/clinic ____

(Facility name and address)

I verify that patient

__________________ ________________ ___________________

(Name) *(Middle Name)* *(Last Name)*

☐ ***Did not test positive for drug use or abuse, including but not exclusive to: Narcotics, Opiates, Amphetamines and Cannabis***

☐ ***Lab report attached***

☐ ***Did not exhibit symptoms of alcoholism or abuse of prescription drugs***

Physician Signature/title ____

Date______________________ Physician License Number ___________________________

Physician Address and Phone Number ____

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