### Medical Examination Report

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** |  |  |  |  |  |  |  |
| **Date of Birth** |  |  |  | **Age** |  | **Gender** |  |
| **Pulse rate** |  | **Blood pressure** |  | **Height** |  | **Weight** |  |

**Emergency Contact Numbers.** *Please provide two (2) emergency contacts.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Relationship** |  | | |
| **Daytime phone number** |  | **Mobile number** |  |
| **Postal address** |  | | |
| **Email** |  | | |
|  |  |  |  |
| **Full Name** |  | | |
| **Relationship** |  | | |
| **Daytime phone number** |  | **Mobile number** |  |
| **Postal address** |  | | |
| **Email** |  | | |

|  |  |
| --- | --- |
| **Do you need any mobility assistance?**  *If yes, please give details.* |  |
| **Do you have any disabilities CWM should be aware of?** *If yes, please give details.* |  |
| **Do you have known allergies?** *If yes, please give details.* |  |
| **Are you aware of any medical conditions that may hinder your participation to the TIM Programme?** *If yes, please give details.* |  |
| **Special Dietary Requirements** |  |

***IMPORTANT: To be completed by Attending Physician.***

|  |  |
| --- | --- |
| **Any family history of disease?** |  |
| **Any serious operations, injuries or illness in the past?** |  |
| **Any infectious diseases?** |  |
| **Any eye defects? If yes, are spectacles worn and satisfactory?** |  |
| **General condition** |  |
| **Any ear disease/s?** |  |
| **Are mouth and throat healthy?** |  |
| **Teeth are well cared for?** |  |
| **Are heart and lungs healthy?** |  |
| **Result of chest X–ray** |  |
| **Any signs of hernia?** |  |
| **Urine: Any albumen? Any sugar?** |  |
| **Any organic, nervous or other disorders?** |  |
| **Any functional disorders?** |  |
| **Is the applicant emotionally well-balanced?** |  |
| **Is there any tendency to depression or history of it?** |  |
| **Have you any knowledge of the applicant’s lifestyle and is there any evidence of abuse of alcohol or drugs?** |  |
| **Do you consider that there are any medical reasons why the applicant should not go abroad for further training?** |  |
| **Does the applicant need any special diet or regular medical treatment of any kind?** |  |

### ATTENDING PHYSICIAN’S CERTIFICATION

I hereby certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is physically **fit / unfit** to participate in the Training in Mission Programme 2020 of the Council for World Mission.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature over Printed Name of Attending Physician

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Registration No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_