U.S. Department of State Academic Exchanges
Participant Medical History and Examination Form
Fulbright U.S. Scholar Program

Having been selected to participate in a U.S. Department of State international educational exchange program, you are required to submit a completed Medical History and Examination Form. The information provided by you and your medical examiner will remain confidential and will be responsibly shared with appropriate professionals for grant administration purposes only.

Participants will complete **Parts I, II, III, and IV** prior to the medical examination. You should complete these sections electronically by typing your responses directly into the response boxes. If the space provided is not sufficient, you may attach additional pages. **Parts V, VI, VII, and VIII** must be completed by a qualified, licensed physician, doctor, or nurse practitioner no more than six (6) months before your grant start date. Examinations conducted by telemedicine are allowable only if you cannot meet in-person with your physician. Telehealth visits should be synchronous in real time with audio-video communication. Telehealth audio communications alone are not acceptable. Instructions for filling out the form are unchanged for telehealth exams except that the examining physician may mark items in **Part VII** as not applicable to a telemedicine visit. At the discretion of the examining physician and/or IIE's medical consultant, an in-person examination may be required for participants with certain types of pre-existing conditions; for those with ongoing conditions including abdominal masses or heart signs like murmurs; or for other concerns raised by a participant's medical history.

The purpose of this form is to confirm health status and plans for continuing care in your host country, as well as for medical clearance, upon which a grant is contingent. The information will also help Fulbright program staff be of maximum assistance to you should the need arise while you are on program. Mild physical or psychological disorders can become serious under the stresses of life in an unfamiliar environment. It is important that program administrators in the U.S and abroad be made aware of any medical, psychological, physical, and emotional condition(s), past or current, which might affect you while on your program.

The Medical Examination History (Part VI), Medical Examination Report (Part VII), and Physician's Statement (Part VIII) must be completed in English by a licensed physician, doctor (MD, DO, or foreign equivalent), or nurse practitioner (NP) who is not a member of your family and uploaded into the IIE Participant Portal before your participation in the program can be confirmed. Violation of this policy may result in termination or revocation of your grant. If the form is completed by a physician's assistant or registered nurse (RN), it must be cosigned by a licensed physician, doctor, or nurse practitioner.

Failure to disclose your current medical issues or medical history to your medical examiner, either during an in-person or telemedicine visit, may result in termination or revocation of your grant.

If there are any significant changes in your medical, psychological, physical, or emotional condition(s) after you submit your Medical History and Examination Form, you must notify your Fulbright program administrator.

Your award is contingent upon your submitting the **Medical History and Examination Form** by stated deadlines and remains contingent until the information is reviewed and satisfactory medical clearance is issued.

INSTRUCTIONS TO PARTICIPANTS

In advance of your medical examination:

- Complete **Parts I, II, III, and IV** on your own prior to the physical examination.
- If the space provided for further explanation is not sufficient, you may attach additional pages. Be sure to note this in the response box, e.g., continued on a separate page.
- Familiarize yourself with the instructions to the physician.
- Understand the scope of the clinical examination and the tests required for your age and/or known condition so that you can be sure that the requirements of the form will be met.

At the time of your medical examination:

- Ensure that your health is evaluated in **Parts VI and VII** and that the form is signed by a licensed physician, doctor, or nurse practitioner. (Although medical offices sometimes use a physician's assistant or R.N. to help perform the examination and tests, only a licensed physician, doctor, or nurse practitioner may sign the form.)
- Ask your medical examiner to return the completed report, including his/her signature and title (MD, DO, NP, etc.), and test results to you as soon as possible.
- Check the form to make sure that **Parts VI, VII and VIII** have been completed by your medical examiner. If the form is incomplete, illegible, or if the results of the required tests are not reported, Fulbright program staff will return the form to you. This step costs time and may require a return visit to your medical examiner. Please prevent such delays.

Following the medical examination:

- Compile your medical report to include pages 2-10. Insert additional statements and test results following the relevant pages.
- Sign and date the form on page 10.
    - Electronic signatures are acceptable in the following formats: Adobe digital or equivalent with timestamp, inserted .jpg image, or mouse-drawn signature. Ink signatures are also acceptable.
- Scan the entire report into a single **PDF document. This is the only acceptable upload format.**
- **Name your scanned document**: Primary Host Country-Last Name-First Name-MedForm (e.g., Vietnam-Jones-John-MedForm)
- You will upload your signed and completed Medical History and Examination Form to the IIE Participant Portal. https://connect.iie.org/user/login

PART I: PARTICIPANT BACKGROUND AND CONTACT INFORMATION: *To be Completed by Participant*

Please type your responses to Parts I-IV directly into this form and print prior to medical examination.

NAME: *Last* *First* *Other*	
DATE OF BIRTH: *MM/DD/YYYY*	SEX:
PRESENT ADDRESS: *Home or Residence* *City* *State* *Country*	
If known, provide Grant Location – City and Country: Briefly describe (e.g., urban, rural, climate, etc.)	
GRANT DATES (approximate if unknown): From : *MM/DD/YYYY* To: *MM/DD/YYYY*	

Will you be covered by private health insurance while on your program? Yes No

If yes, complete the following information. In addition, please confirm with your provider that your coverage extends to your time overseas for your award. Be aware that your existing coverage will remain your primary insurance for the duration of your grant.

Name of Health Plan/Health Care Provider:	
Health Plan ID #:	
Health Plan Effective Date:	
Health Care Provider Address:	

Please provide the names of medical professionals consulted within the last 3 years, except for routine physical examinations. List your primary care physician as well as any specialists. *(Submit an additional form as needed).*

NAME	SPECIALTY or Primary Care	TELEPHONE #
	Primary Care Physician	

EMERGENCY CONTACT INFORMATION AND MEDICAL PROXY: *To be Completed by Participant*

Name two individuals to notify in case of emergency.

PRIMARY EMERGENCY CONTACT:	SECONDARY EMERGENCY CONTACT:
Name:	Name:
Address:	Address:
Cell phone number:	Cell phone number:
Home number:	Home number:
Office number:	Office number:
Email:	Email:

While your academic exchange program does not require that you have established a medical proxy – a medical proxy is an individual who is informed of and can make decisions about your medical wishes on your behalf if you are unable – it is strongly recommended that you consider this option for any emergency medical situations that may result while you are abroad. Should you already have a designated medical proxy, please indicate them below and provide a copy of the supporting documentation along with your medical examination results.

If you have a legal medical proxy, indicate them below and provide a copy of the supporting documentation. (Most U.S. states have forms for the purpose of designating a medical proxy.):

MEDICAL PROXY CONTACT *(Optional)*:
Name:
Address:
Cell phone number:
Home number:
Office number:
Email:

PART II: PARTICIPANT MEDICAL HISTORY: *To be Completed by Participant*

To be completed by the participant prior to the Medical Examination.

Have you ever been diagnosed with/treated for any of the following conditions? Please indicate by answering YES or NO.
YES answers must be explained in the space below, indicating dates, nature of diagnosis and treatment, as well as the current status. Attach additional pages if necessary. Further explanation may be required in **Part VI** which is completed by the medical examiner. For conditions that do not apply to you, please indicate with a check in the NO column.

For any items checked "Yes," the physician may recommend a test to allow for further explanation of the current status of the condition and/or the prognosis or outcome.

MEDICAL HISTORY					
CHECK EACH ITEM	**YES**	**NO**		**YES**	**NO**
Frequent or severe headaches			Fainting spells (syncope)		
Epilepsy or seizures			Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure		
Stroke			Eye disease or vision impairment (other than corrected refractive error)		
Hearing impairment			Severe allergies, including environmental, insect stings, food, and medication		
Tooth or gum disease (periodontal disease)			Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.)		
Asthma, emphysema, persistent cough, or other lung conditions			Severe skin disorder		
Tuberculosis			HIV infection, AIDS		
High blood pressure			Cancer in any form		
Genito-urinary disorder			Depression, anxiety, excessive worry, or related condition		
Hormonal disorders, incl. thyroid			Schizophrenia, psychosis, bi-polar disorder, or related condition		
Diabetes mellitus (high blood sugar, sugar in urine)			Anorexia, bulimia, obsessive-compulsive disorder or related condition		
Sickle cell anemia, excessive bleeding, blood clots or other blood disorder			Drug or alcohol abuse		
Gastrointestinal disorders, including ulcers and ulcerative colitis			Other		

Please explain any items above to which you answered YES, as well as any other health conditions (medical, psychological, physical, and emotional) you have experienced in the last three (3) years. Please include diagnosis, dates of occurrence, type and dates of treatment, medications, outcome, and current status. Attach additional pages if necessary.

PART III: VACCINATION HISTORY: *To be Completed by the Participant*

To be completed by the participant prior to the Medical Examination. **NOTE: COMPLETION OF THIS SECTION IS RECOMMENDED, BUT NOT REQUIRED. IT IS THE PARTICIPANT'S RESPONSIBILITY TO DETERMINE ANY TEST SPECIFICALLY REQUIRED BY THE HOST COUNTRY.** If exact dates of immunizations are not known, list month and year or just year.

Below are the generally recommended vaccinations for foreign participants traveling to the United States only. Participants from the U.S. traveling abroad should discuss with their physicians the relevance of vaccinations related to the participant's grant location. Individuals are advised to consult the CDC travel website: http://wwwnc.cdc.gov/travel/destinations/list

POLIO (Three or more doses)	**Dates of immunization:**
DIPHTHERIA, PERTUSSIS, TETANUS (Three or more doses, one within the past 10 years)	**Dates of immunization:**
MEASLES – MUMPS – RUBELLA (MMR) (Or list individual Measles, Mumps, and Rubella immunizations below)	**Date of immunization:**
MEASLES Dates of Live Immunization (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of measles titer**	**First immunization date:** **Second immunization date:** **(or) Date of Disease:** **(or) Date and result of measles titer:**
MUMPS Dates of Immunization (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of mumps titer**	**First immunization date:** **Second immunization date:** **(or) Date of Disease:** **(or) Date and result of mumps titer:**
RUBELLA Dates of Immunization (two required, at least one month apart) **(or) Indicate date and results of rubella titer** ***Note**: History of disease is not acceptable proof of immunity to rubella*	**First immunization date:** **Second immunization date:** **(or) Date and result of rubella titer:**
COVID-19 Vaccinations (Please list manufacturer and date for each dose)	**First Dose details:** **Second Dose details:** **Other Dose details:** **Booster / Add'l Doses:**

PART IV: PLAN FOR CONTINUING CARE WHILE ON GRANT: *To be Completed by the Participant*

To be completed by the participant prior to the Medical Examination.

It is important that you consider how you will manage your medical, psychological, physical, and emotional health needs while overseas. If you have a condition that requires ongoing care (e.g. monitoring or testing, maintenance medication, medical devices or supplies) you must plan in advance to safeguard your wellbeing. It is your responsibility to ensure that you will be able to purchase maintenance medication in and/or receive mail order prescriptions in your host country.

You should ensure that you understand the Accident and Sickness Program for Exchanges (ASPE), which is a limited health benefit plan provided to exchange participants while on program in their host country. Please review the ASPE Guidebook available at https://aspe.imglobal.com/, including the following sections:

- Benefit Coverage, beginning on page 11
- Benefit Exclusions, beginning on page 15
- Outside the U.S.: Medical Network, found on page 19
- Outside the U.S.: Prescription Drugs, beginning on page 21
- ASPE Compass (Mental Health Assistance and Crisis Support Hotline), found on page 24
- Teledoc, beginning on page 25

You should evaluate your specific health needs to determine whether you need to continue your current health insurance coverage and/or garner additional health insurance coverage while overseas, in addition to ASPE coverage.

Please provide evidence of your advanced planning by responding to the questions below. If the space provided is not sufficient, you may attach additional pages.

1. If you plan to regularly meet with a health care provider or mental health professional while on grant, please specify what type of provider (e.g. neurologist, oncologist, psychiatrist, etc.), the condition being treated, and the anticipated frequency of appointments.

2. Please list any testing, medications, medical devices, and/or medical supplies, support, resources, etc. that you will require while on grant and the condition for which they are needed (such as diabetes, high blood pressure, anxiety, bipolar disorder, depression, low vision, etc.).

3. Detail your plans for securing the care specified above in questions 1 and/or 2 while in your host country. Due to regulations regarding controlled substances and/or prescription medications, drugs available in the United States are not necessarily available overseas. Before leaving the United States, you will need to determine if there are any restrictions on prescriptions from the United States. Please note below whether your medication is in compliance with the laws and entry requirements of your host country and/or how you will be able to get your required medication while on program. For more information refer to the ASPE Guidebook, beginning on page 21.

PART V: INSTRUCTIONS FOR THE MEDICAL EXAMINER

The individual you are examining plans to participate in an international educational exchange program and intends to reside in another country for an extended period of time. Some locations are remote and may have limited medical support from doctors, nurses, laboratory facilities and hospitals. You are asked to carefully consider the applicant's general fitness and medical, psychological, physical, and emotional health as it relates to successful completion of the exchange program.

Please evaluate thoroughly all items listed above in **Part II: PARTICIPANT MEDICAL HISTORY, Part III: VACCINATION HISTORY, and Part IV: PLAN FOR CONTINUING CARE WHILE ON GRANT**. It is important that you:

- Discuss medical history with the participant, conduct a general medical examination, and respond to the questions on pages 8, 9, and 10.
- If the space is not sufficient for a thorough explanation, you may attach additional pages.
- Enter N/A in the space if the question is not applicable to the participant.
- There are **no specific laboratory tests required**, although the exchange program may request further testing based on the participant's medical history. Physicians are encouraged to obtain appropriate tests as indicated by the medical history and results of the physical examination or place of grant activity. For example, G6PD for participants in malarial areas, recent blood sugar determination for diabetic patients or CD4 counts for patients with HIV infection.
- Order and record (or attach copies of) all relevant laboratory tests or necessary data. If there are test results within the past six months, please also attach copies.
- After completing the medical examination, record all findings on pages 8, 9, and 10. *Only the results of a physical exam performed no more than six (6) months prior to the grant start date may be reported*.
- Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment. Please indicate your overall opinion of the examinee's health on page 10.
- Sign and date page 10.
    - Electronic signatures are acceptable in the following formats: Adobe digital or equivalent with timestamp, inserted .jpg image, or mouse-drawn signature. Ink signatures are also acceptable.
    - If this form is completed by a physician's assistant or registered nurse (RN), it must be cosigned by a licensed physician, doctor, or nurse practitioner.

PART VI: MEDICAL EXAMINATION HISTORY: *To Be Completed by Medical Examiner*

1. If the participant answered "YES" to any of the conditions listed in the medical history in **Part II**, please discuss with participant and comment below. Include dates of occurrence, treatment and outcome, if not indicated in the participant's explanation, and if and how the condition may impact participation in the program abroad.

2. Has the participant ever had any significant or serious illness or injury not mentioned in the medical history? If so, explain the nature of the problem and outcome.

3. Please explain any operations (surgical procedures) the participant has had that may impact the participant's experience on the program, including date of operation and outcome.

4. Has the participant ever been hospitalized for any reason? If so, list the condition(s), provide dates of treatment, and explain the outcome.

5. Has the participant ever seen a psychiatrist, psychologist, or psychotherapist? If so, list the condition(s), provide dates of treatment, and explain the outcome.

PART VII. MEDICAL EXAMINATION REPORT: *To be Completed by Medical Examiner*

THIS MEDICAL EXAMINATION REPORT MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND LICENSED PHYSICIAN, DOCTOR, OR NURSE PRACTITIONER AFTER REVIEWING THE EXAMINEE'S MEDICAL HISTORY (PART II) AND PLAN FOR CONTINUING CARE WHILE ON GRANT (PART IV), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE MEDICAL EXAMINER MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS IN THE SPACE PROVIDED.

Note: Results of tests and X-rays included in this medical evaluation must be no more than six (6) months prior to the date of the participant's departure from the United States.

Please type or print in ink.

PARTICIPANT'S NAME: _____
Last *First* *Other*

HEIGHT: *(in or cm)* _____ **WEIGHT**: *(lb or kg)* _____

BLOOD PRESSURE: *Syst./diast.* _____ **RESTING HEART RATE**: _____

CLINICAL EVALUATION

The medical examiner must mark each item by entering an "X" in the NORMAL or ABNORMAL column. Abnormal findings must be fully explained in the space provided. Attach additional pages if needed.

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
Head and neck			
Hearing Acuity			
Visual Acuity (with corrective lenses, if used)			
Lungs and chest			
Heart and vascular system			
Abdomen			
Breasts			
Genito-urinary			
Musculoskeletal			
Gastrointestinal			
Lymphatic			
Neurologic			
Skin			
Psychiatric			

1. List all the medications taken by the participant <u>in the past two (2) years</u>.

2. List all specific medications (generic or name brand) <u>currently</u> being taken by the participant, whether on a regular or as needed basis.

3. List all medical devices being used by the participant (e.g. CPAP machine, glucose monitor, prosthesis, etc.).

4. List any laboratory tests administered as part of this medical examination. Indicate type of, and reason for, test and the results. Attach additional information or documentation where appropriate.

PART VIII: PHYSICIAN'S STATEMENT: *To be Completed by Licensed Physician, Doctor or Nurse Practitioner*

NOTE: IF THIS FORM IS COMPLETED BY A PHYSICIAN'S ASSISTANT OR REGISTERED NURSE (RN), IT MUST BE COSIGNED BY A LICENSED PHYSICIAN, DOCTOR, OR NURSE PRACTICIONER.

☐ Select if exam conducted via telemedicine. Please note any concerns not addressed via this format.

Based on your physical examination and on the participant's medical, psychological, physical, and emotional history, including the **Part IV: Plan for Continuing Care While on Grant**, do you consider the participant able to study, teach, or conduct research in the country indicated on page 2 of the form? (Circle or Check One)

Yes **No** **Conditional**

If No or Conditional, please explain:

Signature of Examining/Supervising Licensed Physician, Doctor, or NP: _____

Date: _____

Name of Examining/Supervising Licensed Physician, Doctor, or NP including credentials:

_____

Telephone number: _____ **Email address:** _____

Address: _____

PART IX: PARTICIPANT'S STATEMENT: *To be Completed by Participant*

I certify that I have reviewed the information entered in **Parts I, II III, and IV** and have discussed subsequently with a licensed physician, doctor, or nurse practitioner the information in **Parts VI, VII and VIII**. I have discussed with my medical examiner the need for any additional tests or the need for immunizations, antimalarial drugs, or other prophylaxis based on the region where I will reside abroad. This information is true and complete to the best of my knowledge.

I acknowledge that falsifying or knowingly excluding critical medical or psychological information may jeopardize my participation in this international educational exchange program. Furthermore, I understand that if any of this information is found to be substantially inaccurate or incomplete, it may result in my return home. Failure to disclose my current medical issues or medical history to my medical examiner, either during an in-person or telemedicine visit, may result in termination or revocation of my grant.

Prior to departure, or during the exchange program, I understand that I must immediately notify the Institute of International Education (IIE) of any changes in my medical status or overall health and wellness. During the grant, I must immediately notify the Post or Fulbright Commission, as well as IIE, of any change in my medical status.

I am aware that the information in this form and any attachments (e.g., laboratory test results, X-rays, etc.) will be provided to the administrating agency abroad to help Fulbright program staff be of maximum assistance should the need arise while I am on program.

In the event of a medical emergency or serious illness during the grant program, I authorize release of my medical information and records to the U.S. Department of State or its designated contractual agency.

Participant Signature: _____ **Date:** _____

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