HEALTH CERTIFICATE

ADVENTIST VOLUNTEER SERVICE
www.adventistvolunteers.org

A doctor/medical provider must complete the health certificate. Spouses should submit a separate form.

Applicant Name _____ Date of Birth _____
Day/Month/Year

☐ I agree to this form being shared with relevant organizations who may consider my application.

Desired Country of Service _____ Type of Position _____

Dear Doctor / Medical Provider:

The above applicant desires to volunteer in the country indicated above. Please note that for an extended period of time, the volunteer may be located in a very remote and isolated area where there are little or no provisions for medical treatment or renewal of medical prescriptions. Additionally, the assignment can be physically and emotionally demanding. Please incorporate these considerations into your review and return this form to the address below.

Please indicate if patient:

1. Has experienced a medical problem in the past or is currently undergoing treatment for heart attack, heart surgery, cancer, etc. ☐ Yes ☐ No
2. Has ever been treated or is currently receiving treatment for mental illness, nervous breakdown, depression, emotional or eating disorder, etc ☐ Yes ☐ No
3. Has ever been treated or is currently receiving treatment for a substance abuse problem (e.g. illegal drugs, alcohol, etc.) ☐ Yes ☐ No
4. Is currently receiving treatment for high blood pressure or diabetes ☐ Yes ☐ No
5. Has a condition requiring immediate access to medical services or facilities ☐ Yes ☐ No
6. Has environmental allergies, asthma, etc. ☐ Yes ☐ No
7. Has a condition which limits physical activities ☐ Yes ☐ No
8. Has any learning disability such as dyslexia ☐ Yes ☐ No
9. Is currently taking prescription medication (if yes, please indicate what) ☐ Yes ☐ No

   _____
10. Has been advised of the recommended vaccinations ☐ Yes ☐ No

If you indicated yes to any of the above questions, please explain _____

_____

Has been advised and will undertake the required vaccinations and/or tests (e.g. TB and/or HIV). ☐ **Yes** ☐ **No**

I recommend this volunteer's physical and emotional fitness to serve in _____ **country**

I cannot recommend this volunteer due to _____

_____

PLEASE USE BACK OF PAGE IF NEEDED FOR FURTHER EXPLANATION

_____ _____
Name of Doctor/Medical Provider (please print) Phone Number *(include country and city code)*

_____ _____
Signature of Doctor/Medical Provider Date

When completed, return to Applicant's Home Division Volunteer Coordinator: