Spouse 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

SV-003 6/07

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