

VERS International Internships

Reference Form—Physician/Health Care Professional

Name of Applicant: _____

TO THE APPLICANT: Please complete **Part A** on your own, then review **Part A** and complete **Part B** with your physician. If you have further questions, please call us at 626-398-1010. You may return this form by email at *international.internships@servantpartners.org* or by mail at *Servant Partners P.O. Box 3144*, *Pomona, CA 91769*. All information is treated confidentially.

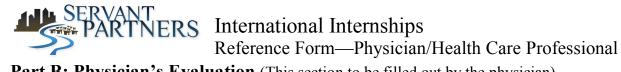
Part A: Self-Report (This section to be filled out by the applicant)

Do you have or have you ever had any of the following? If yes, check box and comment below.								
PERSONAL HISTORY								
Anemia Appendectomy Asthma Back Problems Broken Bones Diabetes Dislocation of Joints Ear Trouble Epilepsy Eye Trouble	Hay Fever Head Injury Heart Trouble Hepatitis Hernia Repair High Blood Pres Insomnia Intestinal Troub Jaundice Kidney Disease		Paralysis Recurrent Diarrhea Recurrent Headache Rheumatism/Arthritis Shortness of Breath Skin Conditions Stomach/Duodenal Ulcer Surgery Tonsillectomy					
Fainting Spells			☐ Tumor/Cancer ☐ Venereal Disease					
Gall Bladder Problems	Low Blood Pressure		_					
ALLERGIES	Mental or Nervous Disorders Weakness FEMALES ONLY							
Penicillin Sulphonamides Serum Food Allergies (specify) Other Allergies (specify)		☐ Excessive Flow ☐ Irregular Periods ☐ Severe Cramps Are you pregnant? ☐ Yes ☐ No						
FAMILY HISTORY Have you or any in your family had any	COMMUNICABLE DISEASES If you have had any of the following, please give dates.							
Arthritis Heart Disease Asthma Kidney Disease Diabetes Mental Illness Epilepsy/Convulsions Stomach Disease Hay Fever Tuberculosis		Chickenpox Scarlet Fever Measles (Rubella) Tuberculosis (TB) Mumps Pertussis (Whooping Cough) Other (specify):		Date: Date: Date: Date: Date: Date: Date:				
COMMENTS For any box checked ab	ove, please commer	nt here. Use add	ditional pages if nece	essary.				



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IMMUNIZATION HISTORY Immunizations are voluntary and are not included in the program costs. If you choose not to be immunized, please indicate your reasons below. Your decision to forego immunization will not affect your acceptance into the program. (Note: Some of the immunizations require multiple dosages over a period of time. Please plan accordingly.)							
Please mark the immunizations you will have completed before beginning this program. Hepatitis A Date: Hepatitis B Date: Typhoid Date: Rabies Date: Malaria Prevention Medication Tetanus/Diphtheria Date:							
I will not be completing the above unchecked vaccination(s) for the following reason(s):							
Are you presently under a doctor's care for any reason? If yes, please explain:							
Are you taking any medications at this time? If yes, please explain:							
Do you now or have you ever received any compensation for disability from any source?							
Have you ever sought treatment for any sort of mental illness?							
Have you ever sought treatment for an eating disorder? If yes, please explain.							



Part B: Physician's Evaluation (This section to be filled out by the physician)

TO THE PHYSICIAN: Please review the information in Part A. Please indicate all conditions that require treatment and notify us of any problems that merit follow-up by health services.

Physician's Name	Phone	Fax	Email	Email				
Office Address		City	State	Zip Code				
How long have you known the applicant?								
<u>APPLICANT'S HEALTH INFORMATION</u> Please check box for any abnormalities in the following systems:								
Height (in inches)	Eyes	[oskeletal				
Weight (in pounds)	Teeth Neuro-P	sychiatric [Endocrine Lymphatic				
Overweight/Underweight?	Cardiova	nscular	Skin Head					
Blood Pressure	Respirate		Ear, Nose, Throat					
Color Perception	Hernia	Hernia		Pelvic				
PHYSICIAN'S RECOMMENDATIO Acceptable without limitations	<u>N</u>							
Acceptable without limitations Acceptable with limitations (please specify below) Acceptable, but should remain in areas where adequate medical care is provided (please specify below) Not acceptable (please specify below)								
COMMENTS								
Physician's Signature:		Date	:					