Associate Missionaries of the Assumption
Medical Certification Form

To be filled out by applicant's physician. Please type or print clearly.

Applicant's Name: _____ DOB_____

Address: _____

Have you been the applicant's regular physician? Yes _____ No _____

If so, for how long? _____

GENERAL INFORMATION

General appearance

_____

_____

Explain any physical abnormalities

_____

_____

PAST HISTORY

Past Hospitalizations (including surgeries):

_____

_____

History of drug abuse: _____

History of alcohol abuse: _____

Significant past illness: _____

FAMILY HISTORY (significant medical/psychiatric):

_____

_____

_____

CURRENT INFORMATION

Medicines (including recurrent non-prescriptives):
_____
_____
_____

Significant present medical problems:
_____
_____

Allergies: _____

Dietary Restrictions: _____

Tobacco/Alcohol Use: _____

Physical Restrictions: _____

GENERAL PHYSICAL

Wt. _____ Ht. _____ B.P. _____ P. _____

Lab (if done recently): U/A _____ CXR _____ CBC _____

Manu _____

Note – for normal and + for abnormal

General appearance _____ Eyes _____ Ears _____

Nose _____ Mouth _____ Adenopathy _____ Chest _____

Breast _____ Heart _____ Abdomen _____Genitals _____

Rectum _____ Skin _____ Neurological _____

Medical Status Exam _____

Please note any abnormalities noted on the previous page

_____

_____

_____

I recommend this patient to live in community and volunteer as an Associate Missionary of the Assumption. To the best of my knowledge, the patient exhibits the good health required to be an effective volunteer.

Yes _____ No _____

Signature of
Physician_____

Date _____

*Printed name and address of Physician's office

_____

*Physician's Phone

***Must be filled out for verification purposes**

Please return form to:

Beth Fleming, Co-Director
Associate Missionaries of the Assumption
11 Old English Road
Worcester, MA 01609
508-767-1356
ama-usa@juno.com