2016 Medical Summary Report

American Work Experience • 335 Greenwich Avenue • Greenwich, CT 06830 • USA
Phone: (+203) 661-9352 • Fax: (+203) 869-6491 • E-mail: info@aweusa.com • www.aweusa.com

INSTRUCTIONS: As a participant on the American Work Experience programme, you are required to have a physical exam before departing for the U.S. This form must be completed and signed by a licensed physician. This form does not affect your employer's decision to hire you or determine your acceptance onto the AWE programme. However, falsifying or failing to disclose information about your health may result in immediate dismissal. If you have any questions or concerns, please contact the AWE office.

Note: ***Both the applicant and physician must sign this form. Please send the original form to AWE and keep a copy for your records.***

IMPORTANT:
The doctor MUST place his/her official stamp here. Alternatively, a signed business card or official letterhead must be attached.

I. TO BE COMPLETED BY THE PARTICIPANT:

AWE # ____ -- _____

Name _____ Birthdate ____/____/_____ Age _____ ❑ Female ❑ Male Do you smoke? ❑ Yes ❑ No

Complete home address _____

Home phone _____ Work phone _____ Fax _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____ Work phone _____ Fax _____

Alternate emergency contact name _____ Phone _____

List any surgery or major illnesses you have had in the last 18 months (include dates): _____

List any chronic, recurring illnesses or medical conditions: _____

Have you ever been under a professional's care for emotional or psychological difficulties? ❑ Yes ❑ No If yes, please describe:

_____

Do you have any dietary restrictions? ❑ Yes ❑ No If yes, please describe: _____

Do you consume alcoholic beverages: ❑ Yes ❑ No If yes, please describe: _____

I hereby certify that the above information is true and correct to the best of my knowledge and I authorize the insurance company or AWE to obtain any information acquired in the course of my examination or treatment.

Applicant's signature _____ **Date** _____

II. TO BE COMPLETED BY THE PHYSICIAN:

Illness/conditions/allergy history *(please give dates when possible):*

❑ frequent ear infections _____	❑ epilepsy _____	❑ asthma _____	❑ mononucleosis _____
❑ heart defect/disease _____	❑ diabetes _____	❑ hay fever _____	❑ depression _____
❑ migraine headaches _____	❑ tuberculosis _____	❑ ivy poisonings _____	❑ mental illness _____
❑ hypertension _____	❑ measles/German _____	❑ insect stings _____	❑ anorexia _____
❑ bleeding/clotting disorder _____	❑ chicken pox _____	❑ penicillin _____	❑ bulimia _____
❑ other _____		❑ other drugs _____	

Immunization history *(please provide dates):*

DPT series (Diphtheria, Pertussis, Tetanus) _____	Polio _____	Typhoid _____
MMR (Mumps, Measles, Rubella) _____	Smallpox _____	Tetanus Booster _____
Hemophilus Influenza B (HIB) _____	Hepatitis B _____	Tuberculin test _____
❑ Pos. ❑ Neg.		

Recommendations: This participant will be working in the United States for up to four months. All positions involve long hours and are very demanding. Is there any information the employer needs to know regarding the applicant's mental or physical condition?

_____

Any treatment to be continued while in the U.S.? _____

Any medications to be administered while in the U.S.? (indicate dosages) _____

Additional comments _____

Physician's name _____ Address _____

Phone _____ Fax _____ Email address _____

Signature _____ **Date** _____

Please use the other side of this form if you have any additional comments

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Please use this side for additional comments you wish to make, or to provide more details.

First Name _____ Last Name _____ AWE ID # _____ - _____

"AWE.., going further to bring people together!"