U.S. DEPARTMENT OF STATE | ENGLISH LANGUAGE PROGRAMS | The World is Your Classroom

AY 2020-2021 Health Verification Form for Fellows

DO NOT COMPLETE AND SUBMIT THIS FORM UNLESS YOU ARE SELECTED FOR A SPECIFIC ENGLISH LANGUAGE FELLOW PROJECT

Instructions for the Selected Candidate

This Health Verification Form (HVF), completed and signed, is due within fifteen (15) business days from the receipt of your Acceptance Letter.

Your participation in the English Language Fellow Program is contingent upon your submitting this HVF by the stated deadline and remains contingent until the HVF information is reviewed and medical clearance is issued.

- ONLY CANDIDATES THAT HAVE BEEN SELECTED FOR AN ENGLISH LANGUAGE FELLOW PROJECT SHOULD COMPLETE THIS FORM. DO NOT COMPLETE THIS FORM PRIOR TO SELECTION.
- THE HVF MUST BE COMPLETED IN ENGLISH, AND MUST BE TYPED OR COMPLETED IN BLUE OR BLACK INK.
- THE HVF MUST BE COMPLETED LEGIBLY, WITH ALL FIELDS FILLED IN; IF NOT APPLICABLE, NOTE N/A. INCOMPLETE HVFs WILL BE RETURNED BACK TO YOU, RESULTING IN A DELAY OF THE REVIEW PROCESS.

Prior to your medical examination:

1. Complete Part I, Personal Data.
2. Read and sign the Accident and Sickness Program for Exchanges (ASPE) Overview.
3. Familiarize yourself with the instructions to the examining health care provider. The examination does not have to be completed in the United States, but the examination must be provided by a licensed physician, doctor (MD, DO, or foreign equivalent), or nurse practitioner, who is not a member of your family.
4. Understand the scope of the examination and any tests that may be required for your age, fellowship location, and/or known conditions so that you can be sure that the requirements of the form will be met during your medical examination.

At the time of your medical examination:

Part II, Medical History, and Part III, Clinical Examination, must be completed in English, and signed on the last page of this form, by a licensed physician, doctor (MD, DO, or foreign equivalent), or nurse practitioner who is not a member of your family. Although physicians' offices sometimes use a physician's assistant or R.N. to help perform the examination and tests, only a physician, doctor, or nurse practitioner may sign the form. Violation of these policies will result in the revocation of your fellowship offer.

When your exam is complete, sign and date the Candidate's Statement on the last page of this form.

When the HVF is complete:

The HVF must be uploaded to the EL Programs online portal. Detailed upload instructions will be provided upon selection to the program. Your HVF will then be submitted to the program's medical examiner for review. If the medical examiner requires additional information, you will be notified; the medical examiner's decision will be contingent on the submission of this additional information. When the review process is complete, you will be notified whether or not you have been medically cleared. Fellowship offers will be rescinded if medical clearance is not issued.

Privacy Statement: The information provided by you and your physician(s) will remain confidential and will be shared with English Language Programs staff and appropriate professionals for fellowship administration purposes only.

PART I: Personal data to be completed by the candidate.

NAME (as on passport):_____ *Last* *First* *Middle*	
FELLOWSHIP LOCATION: _____ *City, Country*	FELLOWSHIP DATES: _____ *MM/YYYY to MM/YYYY*
DATE OF BIRTH: _____ *MM/DD/YYYY*	SEX: ☐ Male ☐ Female

Names of medical professionals consulted within the last three (3) years, except for routine physical examinations. List your primary care physician, as well as any specialists. Attach additional sheets if necessary.

NAME	SPECIALTY or Primary Care	TELEPHONE NUMBER:

EMERGENCY CONTACTS

Name two individuals who could be notified in case of emergency during your fellowship.

PRIMARY EMERGENCY CONTACT	SECONDARY EMERGENCY CONTACT
Name:	Name:
Relationship to you:	Relationship to you:
Cell phone number:	Cell phone number:
Alternate number:	Alternate number:
Email:	Email:

MEDICAL PROXY

A medical proxy is an individual who is informed of and can make decisions about your medical wishes on your behalf if you are unable. While you are not required to establish a medical proxy, it is strongly recommended that you consider this option for any emergency medical situations that may result while you are abroad. Should you already have a designated medical proxy, indicate him/her below and provide a copy of the documentation with your HVF.

Name and relationship to you:
Cell phone number:
Alternate number:
Email:

Accident and Sickness Program for Exchanges (ASPE) Overview

The English Language Fellow Program provides a health benefit plan, Accident and Sickness Program for Exchanges (ASPE), for the duration of the fellowship. ASPE does not provide comprehensive insurance coverage and it does not cover personal travel outside the country of assignment. ASPE is intended only to serve as supplemental coverage while in your country of assignment and it is strongly recommended that you have or purchase comprehensive health insurance with international coverage during your fellowship.

You can review ASPE coverage here: http://usdos.sevencorners.com/

REQUIRED: If you know that you will be covered by health insurance while on your fellowship, complete the following information. Your existing coverage or any coverage you choose to purchase will serve as your primary insurance for the duration of your fellowship.

Name of health insurance provider:	
Medical insurance type*:	
Sub-type*:	
*For "medical insurance type" and "sub-type", indicate one of the following in each corresponding box above: • Employer Plan • Individual Plan • National Health Insurance Plan • Personal Plan • Program Sponsor Plan • University Plan	
Policy ID/number:	
Effective dates (coverage from and coverage to):	
Policy Sponsor:	

I confirm that I have read the information above regarding the ASPE health benefit plan.

_____

Signature

PARTS II and III: Medical history and clinical examination

INSTRUCTIONS FOR THE EXAMINING HEALTH CARE PROVIDER: The individual you are examining has been selected to participate in a fellowship during which s/he will reside abroad for a 10-month period. Some locations are remote and may have very limited medical support from doctors, nurses, laboratory facilities, and hospitals. **It is important that you:**

1. Comment on all items checked "yes" in the medical history section.
2. Record and comment on all findings after completing the clinical examination.
3. Order and attach copies of any relevant laboratory test results.
4. List all medications currently taken by the candidate and provide details on how those medications will be monitored and obtained during the 10-month fellowship.
5. Comment on all active and/or chronic conditions that may require frequent observation or prolonged treatment, and provide details on how these conditions will be managed during the 10-month fellowship.
6. Sign and date the Provider's Statement on the last page.

Fellowship Location: _____ _____
City **Country**

Dates of Fellowship: _____ **to** _____
MM/YYYY **MM/YYYY**

Part II: Medical history to be completed by the examining provider, in consultation with the candidate.

Does the candidate currently have or has s/he ever had any of the conditions or symptoms listed below? "YES" answers MUST be explained in the space provided following this section. You may recommend a test to allow for further explanation of the current status of the condition and/or the prognosis or outcome.

	YES	NO		YES	NO
Frequent or severe headaches			Fainting spells (syncope)		
Epilepsy or seizures			Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure		
Stroke			Eye disease or vision impairment (other than corrected refractive error)		
Hearing impairment			Severe allergies, including environmental, insect stings, food, and medication		
Tooth or gum disease (periodontal disease)			Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.		
Asthma, emphysema, persistent cough, or other lung conditions.			Depression, anxiety, excessive worry, schizophrenia, psychosis		
Tuberculosis			Drug or alcohol abuse		
High blood pressure			Sickle cell anemia, excessive bleeding, blood clots or other blood disorder		
Gynecological disorder			Cancer in any form		
Other hormonal disorders, incl. thyroid			HIV infection, AIDS		
Diabetes mellitus (high blood sugar, sugar in urine)			Severe skin disorder		

If the candidate answered "YES" to any of the items above, explain in detail, including dates of occurrence, treatment and outcome. Attach separate sheets if necessary.

Review the following questions with the candidate. Write N/A if not applicable. Write legibly.

Has the candidate ever had any significant or serious illness or injury not mentioned above? If so, explain the nature of the problem and outcomes.
Explain any operations (surgical procedures) the candidate has had, including dates and major complications.
Has the candidate ever been hospitalized for any reason? If so, explain what condition, provide dates, and explain the outcome.
Has the candidate ever seen a psychiatrist, psychologist, or psychotherapist? If so, explain for what condition and provide dates of treatment and explain the outcome.
List all the medications taken by the candidate in the past three (3) years and explain why the medications were taken. <u>DO NOT INCLUDE CURRENT MEDICATIONS</u>. Space is provided on the following pages for explanations of current medications.

PART III: Clinical examination to be completed by the examining provider.

Height (feet/inches)	Weight (lbs.)	Resting Heart Rate	Blood Pressure

Please check either normal or abnormal for all applicable questions.	Normal	Abnormal	Describe each abnormality in detail. Enter pertinent item number before each comment. Attach additional sheets if necessary.
1. General/Constitution	☐	☐	
2. Skin	☐	☐	
3. Eyes	☐	☐	
4. Ears/Nose/Throat	☐	☐	
5. Head/Neck/Thyroid	☐	☐	
6. Lungs/Thorax	☐	☐	
7. Breasts	☐	☐	
8. Cardiovascular	☐	☐	
9. Peripheral pulses	☐	☐	
10. Abdomen	☐	☐	
11. Male Genitalia/ Prostate (men over 50 only)	☐	☐	
12. Anus/Rectum	☐	☐	
13. Spine/Back/Musculoskeletal	☐	☐	
14. Lymphatic	☐	☐	
15. Neurological	☐	☐	
16. Female Gynecologic	☐	☐	
17. Psychiatric (including any cognitive or behavioral observations)	Y ☐	N ☐	
18. Identifying marks, scars, tattoos	Y ☐	N ☐	

Fellowship Location: _____ _____
City Country

Dates of Fellowship: _____ **to** _____
MM/YYYY MM/YYYY

MEDICATIONS

List ALL medications currently being taken by the candidate, whether on a regular or as needed basis, explain why the medications are taken, and how the medications will be provided during the fellowship. Attach additional sheets if necessary. **It is important for the candidate to understand whether any prescription medications are available in his/her fellowship location. If they are not locally available, discuss this with the candidate and note how they will be obtained prior to and during the fellowship.**

Medication	Start date	Dose	Frequency	Diagnosis (reason for medication) and plan for how the medication will be obtained during the fellowship

PLAN FOR ACTIVE AND/OR CHRONIC CONDITIONS

Explain how any required medical care for all active and/or chronic conditions will be provided during the fellowship; INCLUDING INFORMATION REGARDING MENTAL HEALTH CONDITIONS. Provide details on any functional and/or environmental limitations to these plans, as well as comment on any medical concerns about the candidate that might limit his/her assignment to a specific geographic area (e.g., pollution, mountainous terrain, high altitude, sun exposure, harsh environmental or climatic conditions, etc.) Attach additional sheets if necessary.

Active and/or chronic condition	Treatment plan during the fellowship	Functional and/or environmental limitations

Fellowship Location: _____ _____
City Country

Dates of Fellowship: _____ **to** _____
MM/YYYY MM/YYYY

Please complete the following sections with the specific fellowship location in mind. Write N/A if not applicable.

If blood pressure reading during the clinical examination was abnormal, provide specific plan for how blood pressure will be controlled before departure, and monitored during the fellowship. If medications are necessary, provide the requisite information for these medications in the Medications chart above.
List all drug or other allergies and describe the severity of the reaction. Indicate if the allergy requires emergency epinephrine. If yes, indicate how the epinephrine will be provided during the fellowship.
List all medical devices currently being used by the candidate (for example: insulin pump, prostheses, nebulizers) and describe plans for how these will be provided during the fellowship.

LABORATORY EVALUATION

There are no specific laboratory tests required, although the program may request further testing based on a candidate's medical history. Providers are encouraged to obtain appropriate tests as indicated by the medical history and results of the clinical examination or fellowship location (e.g., G6PD for malarial areas). For example, a diabetic patient should have a recent blood sugar determination or patients with HIV infection should obtain a CD4 count and these results should be submitted with this HVF.

VACCINATIONS

Candidate and physician should discuss relevance of vaccinations related to the fellowship location. IT IS THE CANDIDATE'S RESPONSIBILITY TO DETERMINE ANY VACCINATIONS AND/OR TESTS SPECIFICALLY REQUIRED BY HIS/HER COUNTRY OF ASSIGNMENT. Candidates are highly encouraged to complete, with their health care provider, the internationally recognized "yellow card", documenting all vaccines received, and carry it with them during their fellowship. **More information on vaccines can be found at the Centers for Disease Control Vaccination Information webpage:** http://wwwnc.cdc.gov/travel/page/vaccinations.htm

PROVIDER'S STATEMENT:

Prior to this visit have you provided medical care to this candidate? ☐ Yes ☐ No

Based on your physical examination and on the candidate's physical and emotional history, do you consider the candidate physically and emotionally able to teach abroad in his/her specific fellowship location? Please check one response below.

Please note that the fellowship location may be remote and may have limited medical support from doctors, nurses, laboratory facilities and hospitals. If you have concerns about this candidate's location, mark conditional and explain below.

☐ **Yes –** I consider this candidate able to teach abroad in CITY: _____, COUNTRY: _____.

☐ **Conditional –** I consider this candidate's readiness to teach abroad in CITY: _____, COUNTRY: _____ as conditional upon the following:

☐ **No –** I do not consider this candidate as able to teach abroad in CITY: _____, COUNTRY: _____, based on the following:

Signature of Examining Provider: _____ **Date:**_____

Typed or Printed Name of Examining Provider: _____ **Date:**_____

Provider's Address: _____**Telephone**:_____

CANDIDATE'S STATEMENT:

I certify that this information is true and complete to the best of my knowledge. I reviewed the information presented in this form in its entirety and have discussed with my examining provider the need for any additional tests or the need for immunizations, antimalarial or other prophylaxis based on the region where I will reside abroad.

In the event of a serious illness or medical emergency during the fellowship, I authorize release of my medical records to the U.S. Department of State or its designated contractual agency. I am aware that the information in this form and any attachments, i.e., test results, etc., are being provided to the administering agency as part of the medical clearance process. I acknowledge that falsifying or knowingly excluding critical medical information may jeopardize my program participation.

Prior to departure, or during the fellowship, I understand that I must immediately notify English Language Programs staff of any changes in my medical status or in my overall health and wellness. I understand that if there is any change in my medical condition after my original HVF was submitted and before I travel to my country of assignment, I will need to submit a new HVF to be reviewed by the program's medical examiner. I understand that if any of this information is found to be substantially inaccurate or incomplete, it may be grounds for termination of my fellowship and for my return home.

Candidate's Signature:_____**Date**:_____