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:
____
____
____

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Allergies:
____

Dietary Restrictions:
____

Tobacco/Alcohol Use:
____

Physical Restrictions:
____

GENERAL PHYSICAL
Wt. __________ Ht. __________ B.P. __________ P. __________
Lab (if done recently): U/A __________ CXR __________ CBC __________
Mantu __________
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:
Michelle Sherman, Director
AMA
16 Vineyard St.
Worcester, MA 01603