Health Clearance

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Dear Applicant,

A physician, PA or Nurse Practitioner must complete this Health Clearance Form. Spouse should submit a separate form. Each applicant has the option and is responsible to get additional immunization on top on what is required.

☐ I agree to this form being shared with relevant organizations who may consider my application.

Applicant Name (Please Print)	Applicant Signature (Required)	Date of Birth (Day/Month/Year)

Dear Medical Provider:

The patient will be located in an island for a year or more where there is limited medical facility. The assignment could be physically and emotionally stringent. Kindly incorporate these considerations into your review. (Use reverse side if needed).

Please indicate if patient:

1. Has experienced a medical problem in the past or is currently undergoing treatment for heart attack, heart surgery, cancer, etc. (If yes, please explain) ☐Yes ☐No

2. Has ever been treated or is currently receiving treatment for mental illness, nervous breakdown, depression, emotional or eating disorder, etc. (If yes, please explain) ☐Yes ☐No

3. Has ever been treated or is currently receiving treatment for substance abuse (example: illegal drugs, Prescription medication, alcohol, etc.) (If yes, please explain) ☐Yes ☐No

4. Has a condition requiring immediate access to medical services or facilities. (If yes, please explain) ☐Yes ☐No

5. Has allergies: environmental, medication or food. (If yes, please explain) ☐Yes ☐No

6. Has a condition which limits physical activities. (If yes, please explain) ☐Yes ☐No

7. Is currently taking prescription medication. (If yes, please explain) ☐Yes ☐No

8. Has any other reason why he/she should not be able to serve/practice in a remote island. (If yes, or if with conditions, please explain) ☐Yes ☐No

Physician Asst or Nurse Practitioner (circle one/please print)	Signature	Phone Number (Include country & City Code)	Email Address

Physician (please print)	Signature	License Number of Physician	Date (Month/Day/Year)