

EXCHANGE INTERNATIONAL  
CERTIFICATE OF HEALTH

**YOUR ACCEPTANCE IS CONTINGENT ON RETURNING THIS DOCUMENT TO EXCHANGE INTERNATIONAL AND FULLY COMPLETED IN ENGLISH BY AN APPROVED PHYSICIAN.**

PLEASE TYPE OR PRINT

Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_  
(Print: last name or family name) (first name)

\_\_\_\_\_  
(country)

Part 1

**To be completed and SIGNED BY APPLICANT BEFORE VISITING THE PHYSICIAN**

A. Have you, to the best of your knowledge, ever had any of the following:  
(Each item must be answered "yes" or "no".)

Hernia _____	Intestinal _____	Arthritis _____
Sinusitis _____	Disorders _____	Sciatica _____
Hay Fever _____	Cholera _____	Rheumatism _____
Asthma _____	Smallpox _____	Disease of _____
Goiter _____	Diabetes _____	Skin _____
Cancer _____	Typhoid _____	Venereal _____
Malaria or any _____	Paralysis _____	Disease _____
Type of Fever _____	Pneumonia _____	Mental Disorder _____
Stomach _____	Appendicitis _____	Disease of _____
Disorder _____	Tuberculosis _____	Nervous System _____
HIV Virus (AIDS) _____	Rheumatic Fever _____	Allergies _____
Disease of Eyes _____	Frequent Colds _____	Disease or Disorder _____
Disease of Ears _____	Tonsillitis _____	Of Back or Spine _____
Disease of _____	Gall Bladder _____	Disease of Kidneys _____
Prostate _____	Abnormal Blood _____	Or Genitourinary _____
Rectal Disease _____	Abnormal Blood _____	System _____
Or Disorder _____	Pressure _____	
	Heart Disease _____	
	Or Disorder _____	

If you have answered "yes" to any of the above, give: (1) specific name of disorder:  
(2) duration – specify dates; (3) final results. (If none, write "none".)

\_\_\_\_\_  
\_\_\_\_\_

B. During the past five years, when and for what injury, illness or medical disorder (including any of the above or others) have you been under observation; had medical or surgical advice or treatment; been hospitalized? Give: (1) specific name of disorder; (2) duration – specify dates; (3) final results. (If none, write "none".)

\_\_\_\_\_  
\_\_\_\_\_

C. To the best of knowledge and belief, are you now in good physical health free from impairment or deformity?  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, give specific name of disorder, treatment and present condition.)

\_\_\_\_\_  
\_\_\_\_\_

D. Are you currently taking any injection(s) or medication(s)? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please give name of injection(s) and medication(s) and reason(s) for use.

\_\_\_\_\_  
\_\_\_\_\_

I declare that the above statements are true. I understand that reporting false information is justification for my being asked to return home.

Signature of Applicant \_\_\_\_\_

Part II

To be completed (in English) and signed by physician

A. Insert height and weight, for the rest, enter "N" if normal. Enter "AB" if abnormal and describe in detail under remarks.

Height	_____	Head	_____	Hernia	_____
Weight	_____	Nose	_____	Reflexes	_____
Eyes	_____	Rectum	_____	Heart	_____
Ears	_____	Pharynx	_____		
Neck	_____	Abdomen	_____		

B. Comment on condition of applicant's lungs (indicate if there is any sign of active tuberculosis at present).

\_\_\_\_\_  
\_\_\_\_\_

C. Has the applicant ever suffered from any nervous or mental disorders?

\_\_\_\_\_

D. Does the applicant show any sign of communicable diseases, overfatigue or physical defects?

Yes \_\_\_\_\_ No \_\_\_\_\_

E. In my opinion, the applicant's health and physical condition are:

Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Remarks: Describe any abnormalities noted in Part II – A, B, C, D, E, and add any other comments:

\_\_\_\_\_  
\_\_\_\_\_

Name & Title of Physician (Print) \_\_\_\_\_ Date \_\_\_\_\_

License No. \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_