Physician Certification Form

_____ [print full name of program participant/ patient] has advised me that s/he wishes to participate in international travel with AJWS. I understand that s/he will be traveling to:_____[country] for _____[duration].

I have been advised that while AJWS seeks to include all participants, regardless of physical ability or medical condition, AJWS is limited by the infrastructure and services available in the communities they visit and that medical services and treatment in the country of travel may not be of the same quality as is available in the United States.

In my professional opinion,_____[print full name of program participant/ patient].

☐ IS medically fit to fully and safely participate in this international travel.

☐ IS NOT medically fit to fully and safely participate in this international travel.

☐ IS medically fit to fully and safely participate in this international travel, subject only to the following special requirements or accommodations (please list if applicable):

_____

_____

_____

_____

Physician Name

_____

Physician Signature

_____

Physician Phone Number

_____

Physician Address

_____

Physician City, State, Zip

If there are any medications you take on a routine basis that you would like the AJWS staff traveling with you who are first aid certified to know about, please list them below:

Med #1: _____

Dosage (# of pills): _____

Specific times taken each day: _____

Reason for taking: _____

Side effects experienced: _____

Med #2: _____

Dosage (# of pills): _____

Specific times taken each day: _____

Reason for taking: _____

Side effects experienced: _____

Med #3: _____

Dosage (# of pills): _____

Specific times taken each day: _____

Reason for taking: _____

Side effects experienced: _____

Med #4: _____

Dosage (# of pills): _____

Specific times taken each day: _____

Reason for taking: _____

Side effects experienced: _____