



## Medical information, Part 1 (Part 1: to be completed by the applicant)

Name of applicant \_\_\_\_\_

Birthdate: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tick the appropriate box if you are presently suffering from or have ever had:

- |  |  |   |
|--|--|---|
| Tuberculosis <input type="checkbox"/>          | Diabetes <input type="checkbox"/>  | Asthma <input type="checkbox"/>                               |
| Anaemia <input type="checkbox"/>               | Depression <input type="checkbox"/>  | Bulimia <input type="checkbox"/>                              |
| Eye problems <input type="checkbox"/>          | Dizziness/fainting<br>(Schwindelanfall/Ohnmacht) <input type="checkbox"/>                  | Kidney disease<br>(Nierenerkrankung) <input type="checkbox"/> |
| Arthritis <input type="checkbox"/>             | Heart disease <input type="checkbox"/>   | Migraine/headaches <input type="checkbox"/>                   |
| Ulcers (Geschwüre) <input type="checkbox"/>    | Epilepsy/convulsions <input type="checkbox"/>  |   |
| Anorexia (Magersucht) <input type="checkbox"/> | Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> |   |

If you have ticked any of the above, please give details including dates:

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

Have you ever received counselling and/or medication for any nervous or emotional problems, or for an eating disorder? Yes  No   
If yes, give details including dates

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

Have you ever undergone surgery or been hospitalised? Yes  No   
If yes, give details and dates please

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

Do you suffer from any allergies? Yes  No   
If yes, give details

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

Do you have any chronic or recurring illness? Yes  No

Do you carry an infectious disease such as Hepatitis B or the HIV virus? Yes  No

Are you currently taking any medication: Yes  No

If yes to any of the above please give details

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

I hereby certify that all information given is correct, and that withholding or falsifying any information may result in me being withdrawn from the programme.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## Medical certificate, Part 2 (to be completed by a Medical Doctor)

It is important that we are advised of any physical or mental health problems that may have a bearing on the applicant's ability to participate in a program abroad.

*Da unsere Programme ausschließlich im Ausland stattfinden ist es wichtig, uns über den physischen und psychischen gesundheitlichen Zustand der Bewerberin/ des Bewerbers ausführlich zu informieren.*

Please review the information provided in **Part 1** and give your opinion of the applicant's general state of health:

*Bitte lesen Sie aufmerksam die Informationen der Bewerberin/ des Bewerbers auf der Rückseite durch und teilen Sie uns Ihre Meinung über ihr/ sein generelles gesundheitliches Befinden mit:*

excellent                       good                       poor   
*hervorragend                      gut                      schlecht*

How long have you known the applicant? \_\_\_\_\_  
*Seit wann kennen Sie die/den BewerberIn?*

Is the applicant currently taking any medication? Please specify:

*Ist die/der BewerberIn derzeit in medizinischer Behandlung? Bitte geben Sie genaue Angaben:*

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Does the applicant have any infectious disease or suffer from any chronic illness?

*Leidet die/der BewerberIn an einer ansteckenden oder chronischen Krankheit?*

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Has the applicant ever received treatment for nervous or emotional problems?

*Ist die/der BewerberIn jemals in psychologischer Behandlung gewesen?*

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I hereby confirm that (please add the applicants name) \_\_\_\_\_  
is in good physical and mental health that allows him/her to work in a foreign country.

*Hiermit bestätige ich, dass die/der BewerberIn in gutem physischen und psychischen Zustand ist, der ihr/ihm die Arbeit in einem fremden Land erlaubt.*

\_\_\_\_\_  
Date, Location  
*Datum, Ort*

\_\_\_\_\_  
Doctors signature and stamp  
*Unterschrift und Stempel des Arztes*