

GEORGIA STATE UNIVERSITY STUDY ABROAD PROGRAMS
PHYSICIAN'S CERTIFICATE

NOTE: Certificate Must be (1) Completed and Signed by a Physician Based on an Examination Conducted Within Six Months of the Program Start Date and (2) Submitted to your Program Director together with a completed Vaccine Administration Record **NO LATER THAN** the Date on which Final Payment for Program Participation is Due.

To be completed by Program Applicant:

General Information:

Applicant Name: _____

Program: _____ Program dates: _____

Country(ies) to be visited: _____

To be Completed by Student - Current Medical Information

NOTE: Program Applicants are encouraged to provide the medical information requested below since it may be of significant assistance to the Program Director in the event of a medical emergency. However disclosure is not required.

Current medications:

Allergies:

Special dietary requirements:

Chronic conditions or medical history:

Any other conditions or limitations:

To be Completed by Physician Based Upon Exam Conducted Within 6 Months of Program Start Date

• Date of Medical Examination:

• The program for which the student is applying may involve physical exertion including, but not limited to extensive walking in the summer heat. The program will also require adjustment to different time zones, food and water. In your professional medical judgment, will this applicant's physical condition in any way hinder his/her full participation in such a program? Circle one: **NO / YES**

• Based on my medical examination of this Program Applicant plus the information s/he has supplied above, I (circle one) **Do / Do Not** recommend this individual's participation in the above-identified study abroad program at Georgia State University.

• Please make any comments you deem pertinent to the applicant's ability to participate in the program.

Physician's signature

Date

Address

Phone