uofnbali

Physician's Reference

Name of Applicant _____

Program Applied for (circle one): DTS / Other School / Staff / Volunteer

TO THE PHYSICIAN: the applicant has applied for a program with Youth With A Mission / UofN Bali. The applicant may be required to participate in field trips and outreaches within Indonesia and to other countries. We would appreciate your examination and assessment of the applicant's ability to complete the program.

Return all forms to:
The Registrar
P.O. Box 5008
Jimbaran Bali 80364
Indonesia
Fax: +62 361 702 253
registrar@uofnbali.org

Gender: Male / Female Height _____ Weight: _____

Blood pressure: _____ Pulse rate: _____ Blood Type: _____

General Health Condition (tick one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Other than minor ailments, has the applicant been in an accident or suffer from an ongoing illness which still requires medical or surgical attention? YES / NO If yes, please give details: _____

_____

Is the applicant currently on any form of medication or doctor's care? YES / NO If yes, please give the details:

_____

_____

Are there any physical or psychological concerns that could limit their ability to participate fully in the program?

_____

_____

Does the applicant have or even been treated for any of the following? (please tick and give details below)

☐ hypertension ☐ chest pain ☐ heart disease ☐ stroke
☐ fainting spells ☐ epilepsy ☐ migraine ☐ hepatitis
☐ diabetes ☐ anemia ☐ diseases of muscles or bones
☐ kidney/ urinary system disease ☐ disease of blood or metabolism
☐ disease of brain or nervous system ☐ respiratory disorder/asthma
☐ depression ☐ eating disorder ☐ mental illness

☐ food allergy: _____

☐ drug allergy: _____

☐ other: _____

Details: _____

_____

_____

Any other condition that should be noted? _____

_____

Other relevant history (medical/operation/mental) _____

_____

Doctor's recommendation on fitness to study or go on overseas travel for _____ months.

- □ Acceptable without any limitation
- □ Acceptable with limitations (please specify) _____
- □ Should remain in areas where adequate medical care is available
- □ Not acceptable

How long have you known the applicant? _____ years _____ months

Referee Information

I declare that the contents of this reference are correct to the best of my knowledge

Physician's signature:

Dated

day / month / year

Physician's Name (in block letters, please)

Telephone Number (include country & area code)

Address / Stamp

Email

Please contact us if you have any additional comments. Thank you for your assistance.