LEGACY INSTITUTE
P.O. Box 575, Monrovia, CA 91016

VOLUNTEER APPLICATION
MEDICAL EXAMINATION SUPPLEMENT

This Medical Examination Supplement to the Volunteer Application must be completed and signed by applicant's physician 30 days before arrival at a Legacy Institute project site. **PLEASE PRINT IN INK.**

MEDICAL EXAM / RECOMMENDATIONS AND RESTRICTIONS:

Name: _____ Date: _____, ____
First Middle Last

Sex: _____ Male _____ Female Birth Date: _____/_____/_____
Day Month Year

Address: _____
Street Address City State/Province Zip/Postal

Note to Physician: The applicant has applied for a volunteer position at LEGACY INSTITUTE LEADERSHIP TRAINING CENTER IN CHIANG MAI, THAILAND. Legacy Institute projects are often physically demanding, and maybe conducted in geographically isolated locations in international areas. An existing or potential health problem will not prevent the consideration of an applicant. However, your evaluation of the applicant's physical and mental health is important because some Legacy Institute projects may be unsuitable for an applicant with medical needs that applicant cannot get at a specific project location. Thank you for your comments and evaluation.

I last examined the above named applicant on _____/_____/_____ BP_____ Wt._____ Ht._____

1. In my opinion, the applicant: ☐**IS** ☐**IS NOT** able to participate in a one-year physically and emotionally demanding international public service project.

2. The applicant is receiving routine treatment for the following conditions:

_____

_____

_____

_____

3. Please describe the treatment for the conditions listed above:

RECOMMENDATIONS AND RESTRICTIONS

1. Routine treatment required on continuous basis:

2. Medications required:

Medication	Dosage	Frequency

3. Medically prescribed meal plan or dietary restrictions:

4. Known allergies (including food / drug / environmental sensitivities):

5. Known MSG (Mono Sodium Glutamate) allergy or sensitivity:

6. In your opinion, does the applicant have a condition that may limit or restrict participation in project activities (if any, please describe)?

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Physician name (please print):_____ Title:_____

Address:_____
Street Address City State/Province Zip/Postal

(_____)_____ (_____)_____ Email:_____
Office Telephone Emergency Telephone

To the best of my knowledge, the information provided above is accurate as of the day of the applicant's last examination.

***Physician Signature*:** _____ Date:_____