(THIS MEDICAL FORM "CHEAT SHEET" CAN BE USED FOR BOTH THE FOREIGN STUDENT & VISITING SCHOLAR PROGRAM. "CHEAT SHEET" UPDATED FEBRUARY 2025.)

U.S. Department of State Academic Exchanges
Participant Medical History and Examination Form
Fulbright Foreign Student Program

A CORRECTLY COMPLETED MEDICAL FORM IS REQUIRED TO RECEIVE A DS-2019 FROM IIE.

Having been selected to participate in a U.S. Department of State international educational exchange program, you are required to submit a completed Medical History and Examination Form. The information provided by you and your medical examiners will remain confidential and will be responsibly shared with appropriate professionals for grant administration purposes only. The attached form should be completed and returned to: THE FULBRIGHT OFFICE IN YOUR HOME COUNTRY

THE FULBRIGHT OFFICE SHOULD REVIEW THE FORM FOR COMPLETENESS. IF ANY PART OF THE FORM IS INCORRECT OR MISSING, IT WILL BE THE FULBRIGHT PARTICIPANT'S RESPONSIBILITY TO CORRECT OR COMPLETE THE FORM AGAIN.

Participants will complete **Parts I, II, III, and IV** prior to the medical examination. If the space provided is not sufficient, you may attach additional pages. **Parts V, VI, VII, and VIII** must be completed by a qualified, licensed physician, doctor, or nurse practitioner no more than six (6) months before your grant start date.

The purpose of this form is to confirm health status and plans for continuing care in your host country, as well as for medical clearance, upon which a grant is contingent. The information will also help Fulbright program staff be of maximum assistance to you should the need arise while you are on program. Mild physical or psychological disorders can become serious under the stresses of life in an unfamiliar environment. It is important that program administrators in the U.S and abroad be made aware of any medical, psychological, physical, and emotional condition(s), past or current, which might affect you while on your program.

The Medical Examination History (Part VI), Medical Examination Report (Part VII), and Physician's Statement (Part VIII) must be completed in English by a licensed physician, doctor (MD, DO, or foreign equivalent), or nurse practitioner (NP) who is not a member of your family and returned to your program staff before your participation in the program can be confirmed. Violation of this policy may result in termination or revocation of your award. If the form is completed by a physician's assistant or registered nurse (RN), it must be cosigned by a licensed physician, doctor, or nurse practitioner.

Failure to disclose your current medical issues or medical history to your medical examiner may result in termination or revocation of your grant.

If there are any significant changes in your medical, psychological, physical, or emotional condition(s) after you submit your Medical History and Examination Form, you must notify your Fulbright program administrator.

Your award is contingent upon your submitting the **Medical History and Examination Form** by stated deadlines and remains contingent until the information is reviewed and satisfactory medical clearance is issued.

IT IS THE FULBRIGHT PARTICIPANT'S RESPONSIBILITY TO UNDERSTAND THIS FORM, AND DIRECT THEIR TREATING PHYSICIAN ON COMPLETING THE FORM CORRECTLY.

INSTRUCTIONS TO PARTICIPANTS

In advance of your medical examination:

- Complete **Parts I, II, III, and IV** on your own prior to the physical examination.
- If the space provided for further explanation is not sufficient, you may attach additional pages. Be sure to note this in the response box, e.g., continued on a separate page.
- Familiarize yourself with the instructions to the physician.
- Understand the scope of the clinical examination and the tests required for your age and/or known condition so that you can be sure that the requirements of the form will be met.

At the time of your medical examination:

- Ensure that your health is evaluated in **Parts VI and VII** and that the form is signed by a licensed physician, doctor, or nurse practitioner. (Although medical offices sometimes use a physician's assistant to help perform the examination and tests, only a licensed physician, doctor, or nurse practitioner may sign the form.)
- Ask your medical examiner to return the completed report, including his/her signature and title, and test results to you as soon as possible.
- Check the form to make sure that **Parts VI, VII, and VIII** have been completed by your medical examiner. If the form is incomplete, illegible, or if the results of the required tests are not reported, Fulbright program staff will return the form to you. This step costs time and may require a return visit to your medical examiner. Please prevent such delays.

Following the medical examination:

- Compile your medical report to include pages 2-11. Insert additional statements and test results following the relevant pages.
- Sign and date the form on page 11.
    - Electronic signatures are acceptable in the following formats: Adobe digital or equivalent with timestamp, inserted .jpg image, or mouse-drawn signature. Ink signatures are also acceptable.
- Scan the entire report into a single **PDF or JPG document. These are the only acceptable upload formats**.
- Ensure that your scan is legible, complete, and in the correct order before uploading.
- **Name your scanned document**: Nominating Country-Last Name-First Name-MedForm (example: Vietnam-Jones-John-MedForm)
- Return document to your home country Fulbright Office per their instructions that were provided to you separately.

PART I: PARTICIPANT BACKGROUND AND CONTACT INFORMATION: *To be Completed by Participant*

For Parts I-IV, please type or print in ink and print prior to medical examination.

NAME: PLEASE INDICATE ALL INFORMATION IN THIS SECTION FOR THE FULBRIGHT PARTICIPANT *Last* *First* *Other*	
DATE OF BIRTH: _____ *Month/Day/Year*	SEX:
PRESENT ADDRESS: PLEASE USE HOME ADDRESS IN HOME COUNTRY *Home or Residence* *City* *Country*	
GRANT LOCATION: U.S. CITY OF FULBRIGHT HOST (If known) *City/Country*	GRANT DATES: DATES OF FULBRIGHT GRANT (ESTIMATE IF NOT KNOWN) *From* *To*

Will you be covered by private health insurance while on your program? Yes No

If yes, complete the following information. As well, please confirm with your provider that your coverage extends to your time overseas for your award. Be aware your existing coverage will remain your primary insurance for the duration of your grant.

Name of Health Plan/ Health Care Provider:	THIS CAN BE YOUR HOME COUNTRY INSURANCE, IF IT PROVIDES COVERAGE FOR FULBRIGHT PARTICIPANT IN THE U.S.; OR SUPPLEMENTAL INSURANCE THAT PARTICIPANT PURCHASES FOR TIME IN U.S.; OR BOTH
Health Plan ID#:	
Health Plan Effective Date:	
Health Care Provider Address:	

Please provide the names of medical professionals consulted within the last 3 years, except for routine physical examinations. List your primary care physician as well as any specialists. *(Submit an additional form as needed).*

NAME	SPECIALTY or Primary Care	TELEPHONE #:
DR. BOB SMITH	Primary Care Physician	43 1234 56789
DR. LINDA JONES	SPECIALTY	43 4321 98765

EMERGENCY CONTACT INFORMATION AND MEDICAL PROXY: *To be Completed by Participant*

Name two individuals to notify in case of emergency. PLEASE INCLUDE TWO DIFFERENT EMERGENCY CONTACTS

PRIMARY EMERGENCY CONTACT:	SECONDARY EMERGENCY CONTACT:
Name: SPOUSE, SIBLING, PARENT, FRIEND, ADULT	Name: SPOUSE, SIBLING, PARENT, FRIEND, ADULT
Address:	Address:
Cell phone number:	Cell phone number:
Home number:	Home number:
Office number:	Office number:
Email:	Email:

While your academic exchange program does not require that you have established a medical proxy – a medical proxy is an individual who is informed of and can make decisions about your medical wishes on your behalf if you are unable – it is strongly recommended that you consider this option for any emergency medical situations that may result while you are abroad. Should you already have a designated medical proxy, please indicate him/her below and provide a copy of the supporting documentation along with your medical examination results.

If you have a legal medical proxy, indicate him/her here and provide a copy of documentation. (Most U.S. states have forms for the purpose of designating a medical proxy.):

MEDICAL PROXY CONTACT (*Optional*):
Name:
Address:
Cell phone number:
Home number:
Office number:
Email:

PART II: PARTICIPANT MEDICAL HISTORY: *To be Completed by Participant*

To be completed by the participant prior to the Medical Examination.

Have you ever been diagnosed with/treated for any of the following conditions? Please indicate by answering YES or NO. **YES answers must be explained in the space below, indicating dates, nature of diagnosis and treatment, as well as the current status. Attach additional pages if necessary.** Further explanation may be required in **Part VI** which is completed by the medical examiner. For conditions that do not apply to you, please indicate with a check in the NO column.

For any items checked "Yes," the physician may recommend a test to allow for further explanation of the current status of the condition and/or the prognosis or outcome. ALL SECTIONS BELOW MUST BE CHECKED YES/NO. ANYTHING MARKED "YES" MUST BE EXPLAINED.

MEDICAL HISTORY EXAMPLES					
CHECK EACH ITEM	**YES**	**NO**		**YES**	**NO**
Frequent or severe headaches		X	Fainting spells (syncope)		X
Epilepsy or seizures		X	Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure		X
Stroke		X	Eye disease or vision impairment (other than corrected refractive error)		X
Hearing impairment		X	Severe allergies, including environmental, insect stings, food, and medication	X	
Tooth or gum disease (periodontal disease)		X	Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.		X
Asthma, emphysema, persistent cough, or other lung conditions		X	Severe skin disorder		X
Tuberculosis		X	HIV infection, AIDS		X
High blood pressure		X	Cancer in any form		X
Gynecological disorder		X	Depression, anxiety, excessive worry, or related condition	X	
Hormonal disorders, incl. thyroid		X	Schizophrenia, psychosis, bipolar disorder, or related condition		X
Diabetes mellitus (high blood sugar, sugar in urine)		X	Anorexia, bulimia, obsessive-compulsive disorder or related condition		X
Sickle cell anemia, excessive bleeding, blood clots or other blood disorder		X	Drug or alcohol abuse		X

Please explain any items above to which you answered YES, as well as any other health conditions (medical, psychological, physical, and emotional) you have experienced in the last three (3) years. Please include diagnosis, dates of occurrence, type and dates of treatment, medications, outcome, and current status. Attach additional pages if necessary.

EXAMPLE: PARTICIPANT IS VERY ALLERGIC TO BEE STINGS. PARTICIPANT USES EPIPEN. PARTICIPANT HAD SERIOUS REACTION JULY 18, 2022 AND USED EPIPEN AFTER THE STING. PARTICIPANT VISITED HOSPITAL AND WAS MONITORED UNTIL STABLE. NO ON GOING TREATMENT. PARTICIPANT IN GOOD HEALTH AND IS ABLE TO USE EPIPEN IF NEEDED. NO FURTHER MONITORING NEEDED.
PARTICIPANT NAME BROKE ARM IN JANUARY 2023 AND HAD SURGERY. ARM HAS SINCE HEALED. NO FURTHER CASE OR FOLLOW UP NEEDED. THIS DOES NOT IMPACT THE INDIVIDUAL'S SUCCESSFUL PARTICIPATION IN THE U.S.
PARTICIPANT SOUGHT THERAPY AFTER GRANDFATHER'S PASSING IN MAY 2020 FOR DEPRESSION. SEVERAL SESSIONS LED TO POSITIVE OUTCOME. NO MEDICATIONS AND NO FURTHER TREATMENT NEEDED.

PART III: VACCINATION HISTORY: *To be Completed by Participant*

To be completed by the participant prior to the Medical Examination. **NOTE: COMPLETION OF THIS SECTION IS RECOMMENDED, BUT NOT REQUIRED. IT IS THE PARTICIPANT'S RESPONSIBILITY TO DETERMINE ANY TEST SPECIFICALLY REQUIRED BY THE HOST COUNTRY.** If exact dates of immunizations are not known, list month and year or just year.

PARTICIPANTS MAY NEED SPECIFIC VACCINATIONS FOR THEIR HOST INSTITUTION. IT IS THE PARTICIPANT'S RESPONSIBILITY TO ADHERE.

Below are the generally recommended vaccinations for foreign participants traveling to the United States only. Individuals are advised to consult the CDC travel website: http://wwwnc.cdc.gov/travel/destinations/list EXAMPLES:

POLIO (Three or more doses)	**Dates of immunization:** XXX
DIPHTHERIA, PERTUSSIS, TETANUS (Three or more doses, one within the past 10 years)	**Dates of immunization:** XXX
MEASLES – MUMPS – RUBELLA (MMR) (Or list individual Measles, Mumps, and Rubella immunizations below)	**Date of immunization:** XXX
MEASLES Dates of Live Immunization (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of measles titer**	**First immunization date:** XXX **Second immunization date:** XXX **(or) Date of Disease:** **(or) Date and result of measles titer:**
MUMPS Dates of Immunization (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of mumps titer**	**First immunization date:** XXX **Second immunization date:** XXX **(or) Date of Disease:** **(or) Date and result of mumps titer:**
RUBELLA Dates of Immunization (two required, at least one month apart) **(or) Indicate date and results of rubella titer** ***Note**: History of disease is not acceptable proof of immunity to rubella*	**First immunization date:** XXX **Second immunization date:** XXX **(or) Date and result of rubella titer:**
COVID-19 Vaccinations (Please list manufacturer and date for each dose) NOT REQUIRED FOR THIS FORM, BUT ALWAYS CHECK IN WITH CDC.GOV FOR THE LATEST GUIDELINES ON VACCINATION REQUIREMENTS FOR ENTRY TO THE U.S. ALSO MAKE SURE TO CONFIRM WITH YOUR HOST INSTITUTION THEIR VACCINATION REQUIREMENTS.	**First Dose details:** XXX **Second Dose details:** XXX **Other Dose details:** XXX **Booster / Add'l Doses:** XXX

PART IV: PLAN FOR CONTINUING CARE WHILE ON GRANT: *To be Completed by the Participant*

To be completed by the participant prior to the Medical Examination.

It is important that you consider how you will manage your medical, psychological, physical, and emotional health needs while overseas. If you have a condition that requires ongoing care (e.g. monitoring or testing, maintenance medication, medical devices or supplies) you must plan in advance to safeguard your wellbeing. It is your responsibility to ensure that you will be able to purchase maintenance medication in the United States.

You should ensure that you understand the Accident and Sickness Program for Exchanges (ASPE), which is a limited health benefit plan provided to exchange participants while on program in their host country. Please review the ASPE Benefits Guide available at https://www.sevencorners.com/about/gov/usdos, including the following sections:

- Benefit Coverage, beginning on page 9
- Benefit Exclusions, beginning on page 12
- Inside the U.S.: Medical Provider Network, found on page 15
- Inside the U.S.: Prescription Drugs, beginning on page 17
- Mental Health & Crisis Support Hotline, found on page 21

You should evaluate your specific health needs to determine whether you need to continue your current health insurance coverage and/or garner additional health insurance coverage while overseas, in addition to ASPE coverage.

Please provide evidence of your advanced planning by responding to the questions below. If the space provided is not sufficient, you may attach additional pages.

1. If you plan to regularly meet with a health care provider or mental health professional while on grant, please specify what type of provider (e.g. neurologist, oncologist, psychiatrist, etc.), the condition being treated, and the anticipated frequency of appointments.

   XXX

2. Please list any testing, medications, medical devices, and/or medical supplies, support, resources, etc. that you will require while on grant and the condition for which they are needed (such as diabetes, high blood pressure, anxiety, bipolar disorder, depression, low vision, etc.).

   XXX

3. Detail your plans for securing the care specified above in questions 1 and/or 2 while in the United States. Due to regulations regarding controlled substances and/or prescription medications, drugs available in your home country are not necessarily available in the United States. Please note below whether your medication is in compliance with the laws and entry requirements in of the United States and/or how you will be able to get your required medication while on program. For more information refer to the ASPE Benefits Guide, beginning on page 17.

   XXX

PART V: INSTRUCTIONS FOR THE MEDICAL EXAMINER

The individual you are examining plans to participate in an international educational exchange program and intends to reside in the United States for an extended period of time. Some locations are remote and may have limited medical support from doctors, nurses, laboratory facilities and hospitals. You are asked to carefully consider the applicant's general fitness and medical, psychological, physical, and emotional health as it relates to successful completion of the exchange program.

Please evaluate thoroughly all items listed above in **Part II: PARTICIPANT MEDICAL HISTORY, Part III: VACCINATION HISTORY,** and **Part IV: PLAN FOR CONTINUING CARE WHILE ON GRANT.** It is important that you:

- Discuss medical history with the participant, conduct a general medical examination, and respond to the questions on pages 8, 9, and 10.
- If the space is not sufficient for a thorough explanation, you may attach additional pages.
- Enter N/A in the space if the question is not applicable to the participant.
- There are **no specific laboratory tests required**, although the exchange program may request further testing based on the participant's medical history. Physicians are encouraged to obtain appropriate tests as indicated by the medical history and results of the physical examination or place of grant activity. For example, G6PD for participants in malarial areas, recent blood sugar determination for diabetic patients or CD4 counts for patients with HIV infection.
- Order and record (or attach copies of) all relevant laboratory tests or necessary data. If there are test results within the past twelve months, please also attach.
- After completing the medical examination, record all findings on pages 8, 9, and 10. *Only the results of a physical exam performed no more than six (6) months prior to the grant start date may be reported*.
- Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment. Please indicate your overall opinion of the examinee's health on page 11.
- Sign and date page 11.
    - If this form is completed by a physician's assistant or registered nurse (RN), it must be cosigned by a licensed physician, doctor, or nurse practitioner.
    - Electronic signatures are acceptable in the following formats: Adobe digital or equivalent with timestamp, inserted .jpg image, or mouse-drawn signature. Ink signatures are also acceptable.

PART VI: MEDICAL EXAMINATION HISTORY: *To Be Completed by Medical Examiner*

1. If the participant answered "YES" to any of the conditions listed in the medical history in **Part II**, please discuss with participant and comment below. Include dates of occurrence, treatment and outcome, if not indicated in the participant's explanation, and if and how the condition may impact participation in the program abroad.

   XXX

2. Has the participant ever had any significant or serious illness or injury not mentioned in the medical history? If so, explain the nature of the problem and outcome.

   XXX

3. Please explain any operations (surgical procedures) the participant has had that may impact the participant's experience on the program, including date of operation and outcome.

   XXX

4. Has the participant ever been hospitalized for any reason? If so, list the condition(s), provide dates of treatment, and explain the outcome.

   XXX

5. Has the participant ever seen a psychiatrist, psychologist, or psychotherapist? If so, list the condition(s), provide dates of treatment, and explain the outcome.

   XXX

PART VII. MEDICAL EXAMINATION REPORT: *To be Completed by Medical Examiner*

THIS MEDICAL EXAMINATION REPORT MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND LICENSED PHYSICIAN, DOCTOR, OR NURSE PRACTITIONER AFTER REVIEWING THE EXAMINEE'S MEDICAL HISTORY (PART II) AND PLAN FOR CONTINUING CARE WHILE ON GRANT (PART IV), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE MEDICAL EXAMINER MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS IN THE SPACE PROVIDED.

Note: Results of tests and X-rays included in this medical evaluation must be no more than six (6) months prior to the date of the participant's arrival in the United States. ALL SECTIONS BELOW MUST BE COMPLETED

Please type or print in ink. PLEASE INDICATE ALL INFORMATION IN THIS SECTION FOR THE FULBRIGHT PARTICIPANT

PARTICIPANT'S NAME: _____
Last *First* *Other*

HEIGHT: *(in or cm)* _____ **WEIGHT**: *(lb or kg)* _____

BLOOD PRESSURE: *Syst./diast.* _____ **RESTING HEART RATE**: _____

CLINICAL EVALUATION

Please provide an answer to each item. If it does not apply, enter "n/a" (not applicable) in the NORMAL column. Abnormal findings must be fully explained in the space provided. Attach additional pages if needed.

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
Head and neck			
Hearing Acuity			
Visual Acuity (with corrective lenses, if used)			
Lungs and chest			
Heart and vascular system			
Abdomen			
Breasts			
Genito-urinary/Gynecologic			
Musculoskeletal			
Lymphatic			
Neurologic			
Skin			
Psychiatric			

A test for TB is required (for foreign grantees) at the time of examination, regardless of prior BCG vaccination. The PPD skin test or interferon gamma release assay blood test is acceptable. PPD skin test results over 10mm require a chest X-ray. An abnormal result on either test mandates a chest X-ray to evaluate for active tuberculosis.

Tuberculin Skin Test (PPD) Result (millimeters of induration): _____ ☐ **Pos** ☐ **Neg**

Date of test: _____

OR

IGRA Test Date: _____ ☐ **Pos** ☐ **Neg**

Chest X-ray (if required) Date: _____

A TB TEST IS REQUIRED FOR ALL FULBRIGHT PARTICIPANTS
THIS SECTION MUST BE COMPLETED.
A PPD SKIN TEST OR INTERFERON GAMMA RELEASE ASSAY BLOOD TEST IS ACCEPTABLE.
X-RAY IS ALSO ACCEPTABLE.
IT IS THE PARTICIPANT'S RESPONSIBILITY TO COVER THE COSTS OF THE TB TEST.

Chest X-ray findings: _____
(Note to Physician: X-ray images need not be submitted on film or otherwise)

There are no specific laboratory tests required, although the exchange program may request further testing based on an applicant's medical history. Medical examiners are encouraged to obtain appropriate tests as indicated by the medical history and results of the physical examination or place of grant activity (e.g., G6PD for malarial areas). For example, a diabetic patient should have a recent blood sugar determination or patients with HIV infection should obtain a CD4 count.

NOTE: IT IS THE GRANTEE'S RESPONSIBILITY TO DETERMINE ANY TEST SPECIFICALLY REQUIRED BY HIS/HER HOST COUNTRY.

1. List all the medications taken by the participant in the past two (2) years.

XXX

2. List all specific medications (generic or name brand) currently being taken by the participant, whether on a regular or as needed basis.

XXX

3. List all medical devices being used by the participant (e.g. CPAP machine, glucose monitor, prosthesis, etc.).

XXX

4. List any laboratory tests administered as part of this medical examination. Indicate type of, and reason for, test and the results. Attach additional information or documentation where appropriate.

XXX

PART VIII: PHYSICIAN'S STATEMENT: *To be Completed by Licensed Physician, Doctor or Nurse Practitioner*

NOTE: IF THIS FORM IS COMPLETED BY A PHYSICIAN'S ASSISTANT OR REGISTERED NURSE (RN), IT MUST BE COSIGNED BY A LICENSED PHYSICIAN, DOCTOR, OR NURSE PRACTICIONER.

Based on your physical examination and on the participant's medical, psychological, physical, and emotional history, including **Part IV: Plan for Continuing Care While on Grant**, do you consider the participant able to study, teach or conduct research in the location indicated on page 2 of the form? PHYSICIAN MUST CIRCLE ONE. IF "YES", NO ADDITIONAL EXPLANATION IS REQUIRED.

(Circle one) **Yes** **No** **Conditional**

If No or Conditional, please explain:

PERSON COMPLETING THE PHYSICAL EXAMINATION:

Name	Position	Date
NAME OF MEDICAL DOCTOR	DOCTOR'S POSITION AND CREDENTIALS	DATE OF EXAM

Signature of Examining/Supervising Licensed Physician, Doctor, or NP:

SIGNATURE WITH PEN OR ELECTRONIC _____ **Date:** DATE OF EXAM _____

Name of Examining/Supervising Licensed Physician, Doctor, or NP including credentials:

(CAN BE A STAMP OR HAND WRITTEN OR TYPED BUT MUST BE LEGIBLE) _____

Telephone number: TELEPHONE # _____ **Email address:** EMAIL ADDRESS _____

Address: ADDRESS _____

PART IX: PARTICIPANT'S STATEMENT: *To be Completed by Participant*

I certify that I have reviewed the information entered in **Parts I, II III, and IV** and have discussed subsequently with a licensed physician, doctor, or nurse practitioner the information in **Parts VI, VII and VIII**. This information is true and complete to the best of my knowledge.

I acknowledge that falsifying or knowingly excluding critical medical or psychological information may jeopardize my participation in this international educational exchange program. Furthermore, I understand that if any of this information is found to be substantially inaccurate or incomplete, it may result in my return home. Failure to disclose my current medical issues or medical history to my medical examiner may result in termination or revocation of my grant.

Prior to departure I understand that I must immediately notify the Post or Fulbright Commission of any changes in my medical status or overall health and wellness. During the grant, I must immediately notify the Institute of International Education (IIE) of any change in my medical status.

I am aware that the information in this form and any attachments (e.g., laboratory test results, X-rays, etc.) will be provided to my administrating agency to help Fulbright program staff be of maximum assistance should the need arise while I am on program.

In the event of a medical emergency or serious illness during the grant program, I authorize release of my medical records to the U.S. Department of State or its designated contractual agency.

Participant Signature: SIGNATURE WITH PEN OR ELECTRONIC _____ **Date**: DATE OF SIGNATURE _____

Revision date: January 24, 2025