



MEDICAL CLEARANCE FORM (For Stays of 30 Days or Less)

TC Form 2C

Training Center

Revised November 2014

INSTRUCTIONS: Please ask a medical doctor to fill up this form in English. Attach a scanned copy (preferably in PDF format) with your online application form. Please use **MCF_YOUR LAST NAME** (e.g. MCF_Zeigler) as filename.

To be filled up by the Participant:			
Title of Training Course/Workshop:	Training Dates:		
Name of participant:	Age:	Gender:	Blood Type:
Address:			

To be filled up by the Medical Examiner:	
Is the person examined at present in good health and enjoying full working capacity?	Is the person examined physically and mentally able to <input type="checkbox"/> carry out intensive training or workshop away from his/her <input type="checkbox"/> home?
Does the person examined have any infectious diseases (for example tuberculosis and trachoma) which could present risks for either the candidate or person with whom he/she will come into contact?	Does the person examined have any condition or defect which might require treatment during the workshop?
(For women) Is she pregnant? If yes, would it be safe for her and her child to travel and undergo training? Approximate age or stage of pregnancy:	Place and date of examination

I attest that the participant has undergone medical examination in my clinic:

Signature of Medical Examiner: _____, M.D.
Name (in bold letters): _____
Address: _____

Telephone Number: _____ Mobile Phone Number: _____
Email Address: _____