

TEAM MEMBER PHYSICIAN'S EXAMINATION

*Please NOTE: This Physician's Exam CAN BE WAIVED if the Team Member has had a similar examination within 2 years of the Gateway Team's departure date. If this is the case, please fill in the Team Member's name at the top and the physician's info at the bottom WITH THE DATE of that exam.

Team Member Name: _____ **Date of Birth:** _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Physical Exam

General Appearance:

Heart:

Lungs:

Abdomen:

Extremities:

Eyes:

Ears:

Nose, Throat, Mouth:

Neuropsychiatric:

Other Defects:

Medications Currently Taken – Please list the name, dosage, frequency, and reason for use:

Release for Travel – In your opinion, is there any reason why this individual should NOT travel to an international and/or domestic location or participate in moderate to heavy physical work and exercise?

Please look over the questions on the Medical Information Sheet and make any additional comments where you feel it is appropriate.

Signature of Examining Physician: _____ **Date:** _____

Name of Physician: _____

Office Address: _____

Phone: _____