AROCSA
ASSOCIATION FOR RESEARCH ON CIVIL SOCIETY IN AFRICA
CAPSI
Centre on African Philanthropy & Social Investment

INNOCENT CHUKWUMA AFRICAN NGO LEADERSHIP TRANSITION FELLOWSHIP PROGRAM (ICLTFP)

Medical Fitness Assessment

In order to participate in the 2022 Innocent Chukwuma African NGO Leadership Transition Fellowship Program (ICLTFP) after you have been selected, you **MUST** complete a medical fitness assessment, documented and submitted using the **three forms** provided. The assessment **MUST be carried out by a licensed medical doctor**. This assessment is to ascertain your health status before commencement of the program, to enable AROCSA and CAPSI's staff to be of full assistance to you if and when the need arises.

Instructions for completing the health assessment forms

Before going for the medical examination:

- Please complete Form I by yourself before the medical assessment
- Ensure you sign and date the form (page 9)
- Read carefully and understand the instructions and tests the doctor is required to carry out as shown in Form II and Form III to be sure you can meet the requirements

During the medical examination:

- Ensure the doctor evaluates your health as required in Form II and Form III
- Confirm Form II and Form III are dully signed by the doctor
- Request the doctor to give you the **completed and signed medical report and test results** early enough

* Please note that incomplete forms or forms not duly signed will not be accepted and could lead to delay or denial of your participation in the program.

After the medical examination:

- Compile the medical report (pages 2-9). Please include additional comments or results you deem necessary
- Scan all the reports into **one PDF document**
- Please make sure the scanned **document is readable**
- Name the scanned document as: **2022-ICLTFP-Lastname-Firstname**
- Email the scanned document to programs@arocsa.org
- All forms must be submitted by Friday, 21st January 2022

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Form I: TO BE COMPLETED BY CANDIDATE (Please complete in CAPITAL LETTERS)

Name: ____

Last First Other

Date of Birth: ________________ (DD/MM/YYYY)

SEX: ☐ Male ☐ Female

Present Address:

____

____

House number / Street name. City Country

Do you have a current health insurance that can cover you during your stay in South Africa for the Fellowship program? ☐ Yes ☐ No

If yes, please complete the information below. Please note that your current health insurance indicated below will be your main insurance while in the program. Please confirm with your provider that your insurance covers you while overseas.

Health Insurance Provider:	
Name of Health Insurance Plan:	
Health Insurance Plan ID#:	
Health Insurance Provider Address:	
Start Date of Health Plan:	
End Date of Health Plan: (if applicable)	

Medical Consultations within last three (3) years

If you have consulted a medical doctor / practitioner for issues other than routine check-ups within the **last three** years, please list their names in the space provided below. Please indicate if the physician is your primary care doctor or a specialist.

S/No	Doctor's Name	Primary Care doctor?	Specialist?	Telephone

Emergency Contact and Medical Proxy to be notified in case of emergency.

Please list two persons that you want to be notified in case of emergency. Should you be unable to make a medical decision in case of a medical situation, a medical proxy - a person who knows you and can make medical decisions on your behalf will become necessary. Please name such person below and attach any legal documentation to this effect.

Emergency Contact 1	**Emergency Contact 2**	**Medical Proxy**
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Email:	Email:	Email:
Relationship to you:	Relationship to you:	Relationship to you:

INSTRUCTIONS FOR THE MEDICAL DOCTOR

The person named in Form 1 is selected to participate in a 3-month Fellowship program partly taking place in South Africa. This examination is required for the candidate to receive the best support in case of any medical sitations during the program. It is crucial that you carry out a thorough investigation of conditions indicated in the medical form, following the instruction below:

1. Include comments for any medical condition answered “Yes” in the Medical History form
2. Record results of all physical examinations completed NOT more than six (6) months prior to candidate’s arrival date
3. Request, record and attach relevant lab tests. Also include important results within the past six (6) months prior to February 1, 2022
4. Indicate any recommended follow-up investigations, or medical conditions requiring regular treatments
5. Overall, state your opinion of candidate’s health status (page 9)
6. Please **sign and date** the examination form you completed (page 9)

Form II: TO BE COMPLETED BY QUALIFIED MEDICAL DOCTOR

Please consult with the candidate, and complete the form below. Please include comments for any condition indicated as “Yes” and recommend any test(s) that may be required to ascertain candidate’s current medical status and/or to predict what condition to be expected under specified circumstance.

CANDIDATE’S MEDICAL HISTORY			
Indicate “Yes” if candidate has had in the past or currently has the medical condition or symptom(s) below. Also include dates when condition occurred, treatments given and outcome of treatment			
Condition/ Symptom	**Yes**	**No**	**Comment if “Yes”**
Frequent or severe headaches			
Epilepsy or seizures			
Stroke			
Hearing impairment			
Tooth or gum disease (periodontal disease)			
Asthma, emphysema, persistent cough, or other lung conditions.			
Tuberculosis			
High blood pressure			
Gynecological disorder			
Other hormonal disorders, incl. thyroid			
Diabetes mellitus (high blood sugar, sugar in urine)			
Fainting spells (syncope)			

Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure			
Eye disease or vision impairment (other than corrected refractive error)			
Severe allergies, including environmental, insect stings, food, and medication			
Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.).			
Depression, anxiety, excessive worry, schizophrenia, psychosis			
Drug or alcohol abuse			
Sickle cell anemia, excessive bleeding, blood clots or other blood disorder			
Cancer in any form			
HIV infection, AIDS			
Severe skin disorder			

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Form III. Physical Examination

This section is to **be completed by a qualified Medical Doctor**.

For all conditions below with a "Yes" response, please explain nature of condition, dates of occurrence and treatment, and explain outcome of treatment or condition.

Has candidate:

Had any previous major illness or injury **NOT** included in medical history above? If yes, please explain.
Undergone any surgical procedures that may be of concern during the program?
Ever been hospitalized for any reason? If yes, explain
Ever seen a psychiatrist/psychologist/psychotherapist? If yes, explain.
Taken any medication in last three (3) years? List all medications.
Any **current medications**? List all (indicate whether regular or occasional medication).
Any medical devices being used (like breathing aids, insulin device)? List all devices.

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Medical Examination

*** All test and x-ray results MUST NOT be more than six (6) months by date of candidate's arrival in South Africa for the Fellowship program.**

MEDICAL EXAMINATION FORM			
Applicant's Name: ____ Last First Middle			
Height (inches)			
Weight (Kg)			
Blood pressure			
Resting Heart Rate			
CLINICAL INVESTIGATION Please give an answer for each item and detailed explanation of any abnormal finding			
Condition	**Normal**	**Abnormal**	**Explain abnormal finding**
Head			
Neck			
Neurologic			
Hearing			
Sight (Visual Acuity)			
Heart			
Chest / Lung			
Breasts			
Abdomen			
Muscular / Skeletal			
Skin			
Psychiatric			
Lymphatic			

Tuberculosis test

This test is required irrespective of previous vaccination for BCG. If using a PPD skin test, note that chest X-ray is required for results over 10mm. Interferon gamma release assay blood test is equally acceptable. Any abnormal results of PPD skin or Interferon gamma release assay blood tests requires a chest X-ray to confirm if tuberculosis is active

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: ______________________________

Chest X-ray findings: ____

Physician should please note that you do not need to submit X-ray images on film

Vaccinations

Condition	Dates of Immunization
POLIO (Three or more doses)	
Diphtheria, Pertussis, Tetanus (Three or more doses, one within the past 10 years)	
Measles – Mumps – Rubella (MMR) (Or list individual Measles, Mumps, and Rubella immunizations below)	
MEASLES Dates of Live Immunization (two required, at least one month apart) (or) date of disease occurred (or) date and results of measles titer	Date of 1st Immunization: Date of 2nd Immunization: OR Date Measles occurred: OR Date/Result of measles titer:
MUMPS Dates of Immunization (two required, at least one month apart) (or) date of disease occurred (or) date and results of mumps titer	Date of 1st Immunization: Date of 2nd Immunization: OR Date mumps occurred: OR Date/Result of mumps titer:
RUBELLA Dates of Immunization (two required, at least one month apart) (or) Indicate date and results of rubella titer ***History of disease is not proof of immunity to rubella**	Date of 1st Immunization: Date of 2nd Immunization: OR Date and result of rubella titer:

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DOCTOR'S STATEMENT

From your investigation and evaluation of the candidate's medical history, physical examination and test results, would you consider the candidate physically and emotionally fit to live/study/engage in research writing in South Africa for a period of three months (February – April 2022)

☐ Yes ☐ No

If you answered "No", please provide explanation:

____ ______________________

Signature of Examining Medical Doctor **Date**

Name of Examining Medical Doctor ____

Telephone #: _______________________

Address____

____

CANDIDATE'S STATEMENT

I certify that information I supplied in Form I and information supplied by my physician in Form II and Form III is complete and accurate to the best of my knowledge. Should any serious medical condition/emergency arise during the Fellowship program, I authorize my medical records to be released to relevant authorities. I understand my medical records are provided to organizing agency/ host institution for purposes of medical clearance. I admit that including false or excluding critical medical information may be grounds to deny me participation in the program.

_____________________________________ _______________

Signature of Candidate **Date**

Privacy Policy: Information supplied in these Forms will be used for administrative purposes, shared with appropriate medical staff should the need arise.