

# Certificate of Health

TO BE FILLED OUT, SIGNED, AND DATED BY FAMILY PHYSICIAN

Patient's Full Name \_\_\_\_\_  
(first name) (last name) (middle Initial)

This patient has been approved for travel in remote areas and to participate in volunteer work internationally. Part of the application process is for the applicant to receive a physical exam and be brought up to date on the recommended immunizations. For the applicant's personal safety we are requesting approval from their family physician.

## Recommended Immunizations:

- Hepatitis A
- Hepatitis B
- TDAP - Tetanus, Diphtheria, Pertussis
- MMR - Measles, Mumps, Rubella

By signing below, I am giving consent that this applicant is up to date on the recommended immunizations and has no current physical limitations that would prohibit him/her from travel internationally.

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_