Medical Statement Form

Worldwide Farmers Exchange

This form must be completed in English and signed by a licensed physician. Your application will not be processed without this form. All information will be kept confidential by Worldwide Farmers Exchange.
Any misstatement on this form may result in disqualification from the Program.

Patient last name _____ Patient first name _____

Date of birth _____ Weight _____ ☐ kgs ☐ lbs Height _____ ☐ m ☐ ft Gender ☐ M ☐ F ☐ Other

How long have you known the patient? _____

Dates of most recent immunizations:

COVID-19 _____ Hepatitis A _____ MMR _____

Tetanus _____ Hepatitis B _____

Please answer the following. If the answer is "Yes," please explain in the comment section below.

Are you familiar with the patient's family history?	☐ Yes	☐ No
Is the patient currently receiving medical treatment or taking prescription or other drugs?	☐ Yes	☐ No
Does the patient have an existing medical condition (such as asthma or hernia)?	☐ Yes	☐ No
Has the patient ever suffered from a nervous, mental, or emotional disorder?	☐ Yes	☐ No
Does the patient drink alcohol?	☐ Yes	☐ No
Does the patient smoke cigarettes?	☐ Yes	☐ No
Is there any medical reason the patient should not participate in an agricultural work experience training program in the U.S. which may require strenuous tasks?	☐ Yes	☐ No

Comments

Agreement:

- The WFE Program will require physical labor and the patient is fit and able to participate in such activities.
- The WFE Program may be mentally and emotionally taxing. The patient has no mental or emotional limitations that would prevent them from being able to participate in such activities.
- By signing or typing my name in the signature field below, I acknowledge that all of the information in this Medical Statement Form is true and correct.

Note: WFE recommends a current tetanus immunization before travel.

Physician's signature _____ Date _____

Name and title of physician *(please print)* _____

Address _____ License number _____