



LIFE:

Part #1: Applicant Health Declaration

Part #2 is Doctor's Medical Recommendation

PART 1

Please complete this first part (very clearly, using black ink), then forward it to your Doctor for her/him to complete and send directly to us.

(Applicant; you may fill first part in after consultation with your Doctor)

Date: _____

Applicant's Name: _____

Gender: _____ Date of Birth: _____

Permanent Address Number/Street: _____

City: _____

State/Province: _____

Postal Code _____ Country: _____

Home Phone: _____

"YES" responses DO NOT automatically disqualify anyone from LIFE. Our goal is to uncover special needs you have and situations in which you might need special consideration, support or care. We trust that you will answer these questions honestly and in full. All of the information must be filled out completely and will be treated confidentially. Failure to disclose your health history endangers you and is grounds for dismissal from the program.

Do you have, or have you had - or suffered from/experienced - the following?

| Condition | Yes/No | Date/Period | Condition | Yes/No | Date/period |
|-------------------|--|-------------|---------------------------------|--|-------------|
| Alcohol /drug use | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ADD | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Hyperactivity | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Inflammatory bowel disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Appendectomy | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Irritable bowel syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Lactose intolerance | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Measles | | |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Medication intolerance | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Chicken pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Mononucleosis (Glandular Fever) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Operation(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Phobia(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Ear Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Pneumonia/chronic bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Recurrent back pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Eating Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Recurrent abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | |



| | | | | | |
|------------------------|--|--------------------|----------------------------------|--|--------------------|
| Endocrine disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Sleep Walking | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Condition | Yes/No | Date/Period | Condition | Yes/No | Date/period |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Stress | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Eye problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Travel Sickness | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Tuberculosis or positive TB test | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Frequent colds | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Headaches or migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

If you answered 'Yes' to any questions, please give details.

| Condition name | Details |
|----------------|---------|
| | |
| | |
| | |

Please add more details as necessary in a separate letter (note here if one is written): Yes No

Do you suffer from allergies?

| Allergy | Yes / No | Nature of allergy, degree of sensitivity and severity of reaction |
|-------------------|----------|---|
| Aspirin | | |
| Hay Fever | | |
| Insect bite/sting | | |
| Penicillin | | |
| Food (e.g. nuts) | | |
| Other: | | |
| Other: | | |

Mental Health and specialist care:

Mental Health

During the program you are likely at some times to feel stress, uncertainty, isolation and more. These are normal feelings for people seeking experiences through which to grow. Mental health issues are recognized as widespread today and having them does not disqualify you from being accepted to LIFE unless it is of a nature that would put you in danger to participate. We would not make such a decision without further consultation with you and your doctor. Not telling us about such conditions makes us unable to work with you responsibly or care for you, should you need assistance. Withholding information may be considered reason to be dismissed from the program.

- Do you have or have you had mental health issues? Yes No
- Did you consult with or get treatment from a mental health professional in the last 5 yrs? Yes No
- Are you currently under even periodic therapy or treatment? Yes No
- Do you take, even periodically, medication or drugs related to a mental health need? Yes No

If you answer 'yes to any of these questions', please explain:



PLEASE NOTE: If you answered 'yes' to any of these questions, please submit a letter from your doctor which includes his/her name, address and phone number. This letter should describe the conditions, treatment and any resulting implications for your participation in LIFE. We will not be able to process an application that does not include this letter. Telling us about a mental health issue will not by itself preclude you from participating. It will allow us, in consultation with you, to arrive at a good decision and offer support if desirable or necessary.

Other health issues

1. If your eyesight is an issue, does it cause you a challenge such that you may in certain circumstances require special consideration or support (large screen, etc)? Yes No
If so, please detail:

2. Do you regularly take any medication or rely from time to time on one? If so, please state the medication's name, the reason you take it and the frequency with which you take it.

If you regularly take medicine, or need medicine with you, we recommend that you bring with you the anticipated amount you will need for the year. Can you do that?

Not relevant (explain) Yes No (explain)

Explanation:

3. Can you swim reasonably well? Yes No

4. Are you reasonably fit – for everyday things like taking a cultural tour of a city for a full day, doing a 3-4 hour hike, carrying groceries for several people, moving your own 20kg suitcase? Yes No

If no, please give details:

5. Are you very sensitive to the sun or hot weather? Yes No To cold? Yes No

If yes, please give details:

6. Do you have other needs for which you will or might need special assistance or of which we should be aware? Yes No

If yes, please give details:

7. Do you smoke? Yes No If so, how many packets a day/week/month?

8. Your: Height _____ Weight _____

Immunization History

Certain vaccinations (not all of those noted below) will be required in Israel prior to traveling to India if you have not had them or if they are not current. The below is so that we have a record of your existing vaccinations. Have you had the following vaccinations and, if so, when:

MMR (Measles, Mumps, Rubella) Vaccine Dates #1 _____ #2 _____

Polio Vaccine Dates _____



Tetanus/Diphtheria Vaccine Dates _____

(To be effective, your last booster must have been administered in the past 10 years)

Tuberculin test (Mantoux only) Date Placed _____ Date Read _____

Result: Positive _____ Negative _____

(To be effective your last TB test must have been administered within the past 12 months!)

Hepatitis A Vaccine Dates: #1 _____ #2 _____

Hepatitis B Vaccine Dates: #1 _____ #2 _____ #3 _____

(three doses required)

Chicken Pox Vaccine (Recommended, if no history of disease) Date _____

Japanese Encephalitis? Date: _____

Applicant's Statement

I hereby certify that, to the best of my knowledge, the above medical form is complete in all its details, and I fully realize that any relevant condition, mental or physical, that I am found to have that originated prior to my arrival in Israel, and which is not described in full in this form and/or in an accompanying letter, could be due cause for my dismissal from the program and/or treatment in Israel solely at my expense. I recognize that the LIFE organizers have neither responsibility nor liability arising out of such conditions. I also realize that the medical coverage provided through LIFE is limited and includes only emergency dental treatment.

All medications that I take regularly are at my own expense, and have been detailed in this form (and possibly in an accompanying letter). I give my full permission for all treatment of any nature deemed necessary by doctors in Israel to be extended to me within the framework of the medical services provided by the providers LIFE works with in Israel and in India.

I am aware that usage or involvement with illegal drugs or narcotics or any other medically dangerous practice may be cause for immediate dismissal from the program.

I give permission to LIFE, the staff and agents thereof to contact the Doctors signed on the health-related reference(s) I will supply for the purpose of obtaining necessary information to assist in the selection process for LIFE and, should I participate in the program, also during the year to gather information or medical opinions for other matters related to my health should the need, in their opinion, arise.

Name of Applicant: _____

Signature of Applicant: _____ Date: _____





PART 2: This part should be filled out (only) by a certified medical Doctor.

Doctor's Medical Recommendation for an Applicant to the LIFE International Leadership Development Program.

Background for Medical Recommendation

Because each participant will face many physical and mental challenges on LIFE, it is imperative, as a safeguard to the health of the participant, that the medical form be as complete and precise as possible. There are, therefore, several important elements of the program that the physician should keep in mind while making his/her recommendation:

1. Please learn about the nine-month LIFE leadership development program that takes place in Israel and India at www.LIFEprogram.org. The program starts in Israel for three weeks, transitions to India for four months then returns for a little over four months to Israel. Participants undertake professional internships with leading NGOs and undertake field trips, classroom learning, personal and group projects.
2. The climate in Israel is mostly dry, with semi-arid conditions over a large part of the country. Participants will be touring and working in temperatures that can reach 100 degrees Fahrenheit in the shade.
3. The weather in India may be no less extreme (if humid rather than dry), but there the participant will be exposed to the possibility of stomach bugs, diarrhea, and other systemic diseases that weaken the system. Underlying frailty or chronic problems likely to be exacerbated by this should be noted.
4. The living conditions for LIFE participants will be in a communal setting. They will often be sleeping in dormitory-style housing and eating in communal dining facilities. There will be long, overnight train journeys with potentially little sleep.
5. Work assignments for participants may include some physical labor in the sun.
6. Each participant will be expected to take part in a number of tours and traveling around independently in ways that require walking long distances, climbing, and other potentially strenuous activities.
7. Participants move quite frequently to new assignments or locations with starkly contrasting cultural, physical, economic and social environments. The resultant stress is normal and to be expected.
8. Participants need to have a good level of physical, emotional and mental health and stability in order to meet these demands. This requires the maturity and mental stability to make smooth transitions and deal with stress, uncertainty and last minute changes.



Please complete in very clear handwriting in black ink (for fax legibility)

Date: _____

Doctor's Name: _____

License number and stamp: _____

Name of Clinic/practice: _____

Clinic/practice address: _____

Telephone Number(s): _____

I am willing to be contacted even during the year the applicant is on LIFE, should s/he be accepted and should the cause arise. Yes No

PHYSICIAN'S STATEMENT

Name of Applicant: _____

1. I am not related to the applicant.
2. I have known the Applicant for _____ years.
3. Indicate by tick or circle which is true and complete as necessary:
4. The applicant has been a patient of mine for over _____ years/months (delete one).

OR

The Applicant is consulting with me now for the first time to complete this medical report I have read about the LIFE program and the "Background for Medical Recommendation" on the previous page and understand what is required of participants.

5. To form the opinion at the base of this recommendation, I have taken the following steps:
 - a) I reviewed Part 1 of the Application (pgs1-4) completed by the Applicant Yes No
 - b) I reviewing the applicant's complete / partial (indicate which) medical records which were at my disposal Yes No
 - c) I conducted a physical examination Yes No
 - d) I conducted a medical interview with the applicant Yes No
 - e) I carried out additional tests (blood, urine, etc) Yes No
 - If 'yes', which? _____
 - f) I discussed possible issues of medical concern with the applicant Yes No
6. To the best of my knowledge, the Applicant Health Declaration (information on pages 1-4) is correct. Yes No
7. If, in the last 5 years, the applicant has been under the care of a specialist, is required to continue therapy or treatment, or must continue receiving medication or drugs, I will describe this in a separate typed letter that includes the conditions, prognosis, treatment and any resulting implications for his/her participation in the LIFE program.

I attach / do not attach (delete one) such a letter signed by me.

8. I understand that the LIFE program will rely on this report and recommendation.



9. If I become aware of a change in the applicant's medical condition, I will notify LIFE at:
info@lifeprogram.org

10. In my opinion, based on the demands of the program and my evaluation of the applicant's health, s/he is (circle one):

capable / capable with reservations* / incapable

of participating in the program.

* (if relevant) I have the following reservations or concerns (please write clearly):

Name: _____

Full Address: _____

Telephone Number: _____ FAX Number: _____

E-mail Address: _____

License Number:

Stamp and Signature:

Date: _____

**DOCTOR, PLEASE FAX ALL 7 SHEETS DIRECTLY TO:
1-480-275-3368 WE THANK YOU VERY MUCH.**