



818 Dunwoody Boulevard, Minneapolis, Minnesota 55403
612-374-5800 • 800-292-4625 • fax 612-374-4128 • www.dunwoody.edu

International applicants must submit with application for admission. PLEASE PRINT IN INK.

Name of Applicant _____ Age _____ Nationality _____ Female Male
Address _____ City/Town _____ Country _____
(Street and Number)

NOTICE: Your application is acceptable only when this document is correctly and fully completed in English.

IMPORTANT: All persons entering or re-entering the United States must present proof of successful vaccination against smallpox within the preceding three years. Innoculation against typhoid is also recommended.

PART I. To be completed and signed by applicant before visiting the physician.

a. Check any of the following items which, to the best of your knowledge, you have ever had.

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Intestinal disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Disorder of the gall bladder |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Cholera | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Disease of eyes | <input type="checkbox"/> Abnormal blood pressure |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Disease of ears | <input type="checkbox"/> Heart disease or disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Disease of prostate | <input type="checkbox"/> Disease or disorder of the back or spine |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Typhoid | <input type="checkbox"/> Disease of skin | <input type="checkbox"/> Rectal disease or disorder | <input type="checkbox"/> Disease of kidneys or genito-urinary system |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Frequent colds | |
| <input type="checkbox"/> Malaria or any type of fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Stomach disorder | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Disease of nervous system | <input type="checkbox"/> Disease of the gall bladder | |

If you have checked any of the above, give: (1) specific name of disorder; (2) duration: specify dates; (3) final results.

b. During the past five years, when and for what injury, illness, or mental disorder (including any of the above or others) have you: been under observation; had medical or surgical advice or treatment; been hospital-confined? Give: (1) specific name of disorder; (2) duration: specify dates; (3) final results (if none, write "none.")

c. To the best of your knowledge and belief, are you now in good physical and mental health and free from impairment or deformity?
 Yes No (If no, give specific name of disorder, treatment, and present condition.)

Signature of Applicant _____ Date _____

PART II. To be completed (in English) and signed by physician.

The physician should return this Certificate to: *Coordinator, International Services Division, Dunwoody College of Technology, 818 Dunwoody Boulevard, Minneapolis, MN 55403, U.S.A.*

a. Height _____ Weight _____ Blood pressure _____

Insert "N" if normal; if abnormal, insert "AB" and describe in detail under "Remarks."

Head _____ Neck _____ Nose _____ Hernia _____ Eyes _____ Reflexes _____

Ears _____ Heart _____ Rectum _____ Abdomen _____ Pharynx _____ Lungs _____

b. Report of chest x-ray taken within last six months: _____

c. Blood test for syphilis: positive negative Date _____

d. Has the applicant ever suffered from any nervous or mental disorder? _____

e. Do you consider the applicant able to carry on a full course of study involving long hours of work? Yes No

f. Does the applicant show any sign of communicable diseases, overfatigue, or physical defect? Yes No

g. In my opinion, the applicant's health and physical condition are: Excellent Good Fair Poor

Remarks: Describe any abnormalities noted in Part II and add any other comments. Use other side if necessary.

Name and title of physician _____ License No. _____

Signature _____ Date _____