CERTIFICATE OF GOOD HEALTH

Institute for Continuing Theological Education
Pontifical North American College
00120 Vatican City State
Europe

This Certificate of Good Health has been requested by the Patient listed below for the purpose of gaining admission to the Institute for Continuing Theological Education (ICTE) at the Pontifical North American College (PNAC) in Rome, Italy.

PATIENT'S INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Address: _____

This patient has been under my care for the past _____ years / months *(circle one).* I certify that I have examined the patient within the past 6 months and found him to be presently in good physical and mental health. This patient is, to the best of my knowledge, able to meet the physical requirements to perform all of the activities included in the ICTE program, specifically, the following capability:

(Capability rating: 1 = capable / 2 = moderately capable / 3 = incapable)

• *General:*			
- *Four hours/day classes; five days/week*	*1*	*2*	*3*
- *One-two hours of religious commitment*	*1*	*2*	*3*
- *Pilgrimages & sight-seeing: varies per day (2 – 4 hours optional)*	*1*	*2*	*3*
- *Extensive periods of city walking at times*	*1*	*2*	*3*
• *Mediterranean environment:*			
- *Allergic reaction due to high pollen count*	*1*	*2*	*3*
- *Damp environment / heating system compromised at times*	*1*	*2*	*3*
- *Sudden air pressure changes causing headaches*	*1*	*2*	*3*
- *Catacombs (40 feet underground)*	*1*	*2*	*3*
- *Hilly and cobblestone terrain*	*1*	*2*	*3*
• *Significant cultural challenges:*			
- *Fast moving city*	*1*	*2*	*3*
- *Crowded buses*	*1*	*2*	*3*
- *Common spoken language is Italian*	*1*	*2*	*3*
- *Facilitating Euro currency*	*1*	*2*	*3*
- *Italian meal schedules*	*1*	*2*	*3*
- *High salt content & spices in Mediterranean food*	*1*	*2*	*3*

In your physical & medical assessment, would you recommend this person at this time for the program? ***YES*** ***NO***

I am not aware of any diseases or conditions which would prevent the patient from being physically capable.

_____

Physician's Signature

PHYSICIAN'S INFORMATION

Physician's Name: _____

Physician's Address: _____

Physician's Phone Number: _____

_____ _____

Physician's Signature Date

PLACE PHYSICIAN'S STAMP HERE

Please have the information completed by your primary care provider
Submit the forms to the ICTE in an email as one pdf file to: romeshabat@pnac.org
All questions should be directed to: romeshabat@pnac.org.