MS

THE ROCKEFELLER FOUNDATION

PERSONAL HISTORY RECORD AND APPLICATION

FOR FELLOWSHIP

Date.....

Name in full..... Sex .....

Present address..... .....
(Street and Number) (City) (State or country)

Permanent address .....
(Street and Number) (City) (State or country)

Place of birth..... Date of birth..... Race.....

Citizenship ..... Nationality ..... Religion.....

Single, married, widowed, divorced..... Wife's name .....
(Form of customary legal signature)

Date of marriage..... Number of children..... Age and sex.....

Present position ..... Salary .....

Have you at any time filed an application with any division of the Rockefeller Foundation?.....

.....

When and with whom?.....

Have you any constitutional disorder or physical defects?.....

.....

.....
(Report of medical examiner on blank of the Rockefeller Foundation must be submitted)

Do you speak and understand *English* well?.....

What other languages do you speak?.....

FORM 322

TRAINING:

Type	NAME OF INSTITUTION	First and last years spent there	Degrees	Date
Academic				
High School (Enseignement moyen) (Gymnasium)				
College				
University				
Other				
Medical				
Professional School				
Post Graduate				
Hospital				
Research				
Public Health				
Nursing				
Special Study				

EXPERIENCE:

1. Positions held (scientific, professional, administrative, teaching, business, health)

NAME OF ORGANIZATION	Title of Position	Years of Tenure	Compensation

2. Years of private practice (state when and where) .....

.....

3. Are you legally qualified to practice your profession in your country? .....

REFERENCES (Persons acquainted with your qualifications):

Name	Position	Address

STUDY PLANS AND FUTURE PROSPECTS:

What subject or subjects do you wish to study?.....

What special studies or experience have you already had in these subjects?.....

.....

.....

Where and with whom do you wish to work?.....

When do you wish to begin work, if awarded a fellowship?.....

How long do you wish to study?.....

What are your plans after completing studies, and how definite are these plans?.....

.....

(In addition to this statement the agreement on the back of this page should be signed)

To what definite position do you expect to return, after completing studies?.....

.....

(An official statement on Rockefeller Foundation, Form 323, from governmental or institutional authority should be attached)

REMARKS: (Cite here any additional facts bearing upon your application, such as foreign travel, principal investigations, publications, etc. If publications appeared in a journal, give date and volume number.)

(OVER)

AGREEMENT

Date.....

I hereby agree to return to my own country, at the termination of my Rockefeller Foundation fellowship, to occupy the position for which I am being trained during the term of this fellowship.

Signature.....

EMERGENCY ADDRESSES: (Give names of nearest relatives or other emergency address.)

Name ..... Relationship.....

Address .....

Name ..... Relationship.....

Address .....

Name ..... Relationship .....

Address .....

THE ROCKEFELLER FOUNDATION

MEDICAL EXAMINATION

NOTE: It is kindly requested of the examining physician to write as legibly as possible or to print the answers to *each* question given below. It is necessary to have a comment on any positive findings which would bear seriously on the health of the candidate during a fellowship experience in a foreign country.

Name of Applicant..... Candidate for fellowship in.....

Address.....

FAMILY HISTORY

What relatives have had tuberculosis?.....

Have any relatives had nervous or mental disorders?..... State diagnosis.....

.....

PERSONAL HISTORY

Has applicant ever suffered from any of the following diseases? (State when and give necessary details)

(a) Tuberculosis

(b) Cardiac disease

(c) Gastro-intestinal disorders:
Appendicitis
Gallstones
Dysentery

(d) Mental or nervous disabilities
Indications of "nervous breakdown"

(e) Arthritis

(f) Genito-urinary or renal diseases

(g) Malaria

(h) Acute or chronic respiratory diseases:
Sinus infections
Tonsilitis
Hay fever

(i) When was applicant last successfully vaccinated?

(j) Has applicant had typhoid fever?
When?
Or antityphoid inoculation?
When?

(k) Any disease or injury not mentioned above?

PHYSICAL EXAMINATION

1. General development: good.....; fair.....; poor..... (Check term applicable)

   Nutrition: thin.....; average.....; obese..... (Check term applicable)

   Weight..... Height..... Age.....

   Best Weight..... When?..... Any recent change in weight?.....

2. Skin: Any obvious disease.....

3. Eyes: Lids..... Sight: Right eye..... Left eye.....

4. Ears: Inspection.....Hearing: Right ear.....Left ear.....

5. Glands.....

6. Thyroid.....

7. Condition of teeth and defects to be corrected.....

8. Lungs: Physical findings.....

9. Heart: Any organic lesions

Rate—Standing
Rate—After hopping 25 times
Rate—2 minutes after hopping

Blood pressure: Systolic.....Diastolic.....Name of instrument used.....

10. Abdomen: Girth
Tenderness
Hernia
Palpable: Liver.....; Spleen.....; Kidneys.....; Tumors..... (Positive findings to be explained)

Hemorrhoids

Fistula in ano

11. Indications of mental or nervous disabilities

12. Urine analysis:
Physical appearance
Albumin.....; Sugar.....; Casts.....; Sp. Gr.....

13. Blood:
a. Hemoglobin
b. Red blood corpuscles per cmm

To be reported if conditions warrant:
c. Leucocytes per cmm
d. Differential leucocyte count

14. Are there any facts known to you, not brought out in the foregoing examination, affecting or likely to affect the health of the applicant?

15. Do you consider the applicant a person who would be acceptable to an insurance company as having excellent health?

REMARKS (Please include comments and possible prognosis on any positive findings in history or physical examination):

NOTE TO MEDICAL EXAMINER:

This blank, when completed, should be sent to the official recommending the fellowship, or to the nearest representative of The Rockefeller Foundation. It should not be handed to the applicant.

Signature of Medical Examiner: M.D.

Address:

Date:

RECORD OF IMMUNIZATION

I certify that I have given prophylactic vaccination or inoculation to .....on the dates stated as follows:

1. Vaccination against smallpox:

   a. Date.....

   b. Result.....

2. Inoculation against typhoid and paratyphoid:

   a. First inoculation

      Date .....

      Kind and quantity of vaccine.....

   b. Second inoculation

      Date .....

      Kind and quantity of vaccine.....

   c. Third inoculation

      Date .....

      Kind and quantity of vaccine.....

3. Immunization against diphtheria by injection of toxin-antitoxin mixture:

   (Required only for children under 12)

      Date.....

      Signature of Medical Examiner.....M.D.

Date..... Address.....

Form 325

Place.....

Date.....

To The Rockefeller Foundation
61 Broadway, New York

This is to give assurance that

Doctor.....

Present position.....

.....

in (city) ..... (country) .....

at the termination of his fellowship, should one be granted him, will be given the position of.....

.....

.....

Signature .....

Title or position .....

Official Address .....