

GENERAL EDUCATION BOARD

PERSONAL HISTORY RECORD AND APPLICATION FOR FELLOWSHIP

(NOTE: Please type or print all entries)

Field of Special Interest.....

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.....

..... Other dependents.....

Present Position..... Annual Salary.....

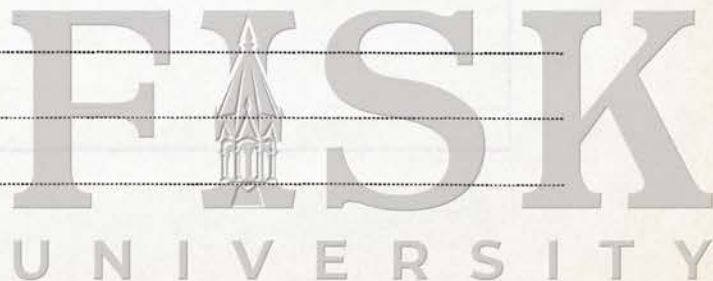
What part, if any, of this salary will be continued if a fellowship is granted?.....

Amount expected from other sources.....

If wife (or husband) is employed, give position and annual salary.....

Have you at any previous time filed an application with the General Education Board or The Rockefeller Foundation?..... If so, give details.....

Have you at any time held a fellowship from any other American institution or agency or are you now an applicant for one?..... If so, give details.....



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

.....

(Applicants may be asked to submit to a medical examination)

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

What languages do you read?.....

TRAINING:

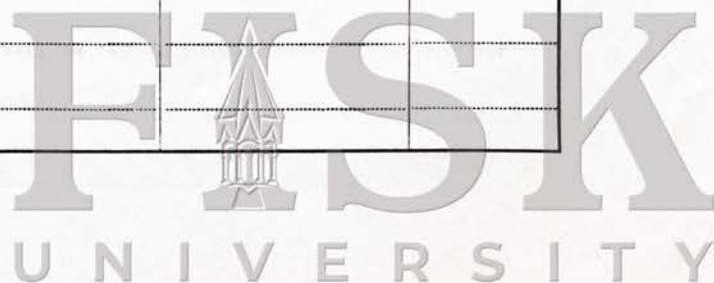
Type	NAME OF INSTITUTION	First and last years spent there	Degrees	Date
Undergraduate				
Graduate				
Special Study (In addition to that stated above)				

Official transcripts of scholastic records (undergraduate and graduate) are required.

EXPERIENCE:

Positions held (teaching, scientific, professional, administrative, business)

INSTITUTION OR ORGANIZATION	Title of Position	Years of Tenure	Annual Compensation



REFERENCES: (Persons acquainted with your qualifications)

Name	Position	Address

PUBLICATIONS: (Give journal, year, page)

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(Copies of your most important published papers should be attached to this blank)

REMARKS: (Cite here additional facts bearing upon your application, i. e., foreign travel, academic and scientific honors, etc.)

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FUTURE PROSPECTS:

What are your plans for the future, and how definite are they?.....

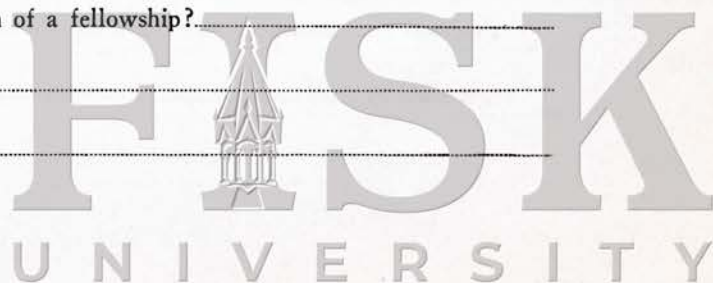
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Have you a definite post to which to return at the expiration of a fellowship?.....

.....

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STUDY PLANS:

What subject or subjects do you wish to study?.....
(It may be desirable to describe in detail on a separate sheet the work you propose to do)

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

Would this study require special facilities, material, or equipment?.....

In what institution and with whom do you wish to work?.....

What tuition or laboratory fees will be required?.....

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

What period of appointment do you wish (in months)?

Will any members of your family accompany you?.....

Who?.....
(Only *your* travel expense will be paid by the Board)

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

Name Relationship.....

Address.....

Name Relationship.....

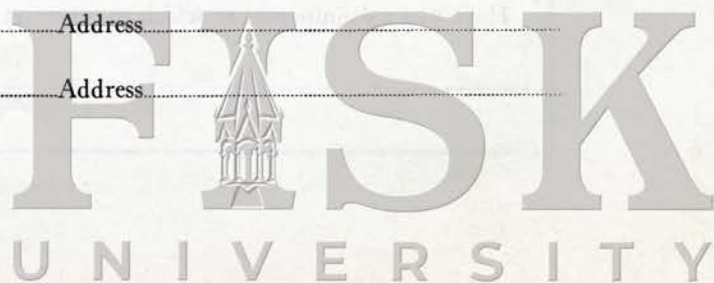
Address.....

Signature

Signatures of Sponsors :

Proposed by:..... Address.....

Seconded by:..... Address.....



GENERAL EDUCATION BOARD

MEDICAL EXAMINATION

Name.....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 | (g) Malaria |
| (b) Cardiac disease | (h) Acute or chronic respiratory diseases:
Sinus infections
Tonsillitis
Hay fever |
| (c) Gastro-intestinal disorders:
Appendicitis
Gallstones
Dysentery | (i) When was applicant last successfully vaccinated? |
| (d) Mental or nervous disabilities
Indications of "Nervous Breakdown" | (j) Has applicant had typhoid fever?
When?
Or antityphoid inoculation?
When? |
| (e) Arthritis | (k) Any disease or injury not mentioned above? |
| (f) Genito-urinary or renal diseases | |

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: To be reported if conditions warrant:
a. Hemoglobin
b. Red blood corpuscles per cmm
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 first-class medical risk, i.e., a person who would be acceptable to an insurance company as having excellent health?

REMARKS (including 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 office of the General Education Board, 49 West 49th Street, New York, N. Y., with a statement of charges for services rendered. 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.....