

THE ROCKEFELLER FOUNDATION  
INTERNATIONAL HEALTH DIVISION  
PERSONAL HISTORY RECORD AND APPLICATION  
FOR FELLOWSHIP

*Fellowships are granted for the purpose of training individuals to occupy positions in connection with governmental public health agencies, with the understanding that a definite acceptable position awaits the applicant upon completion of fellowship studies.*

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)

If single, widowed or divorced have you dependents?.....

Relationship of dependents to applicant.....

If single, do you expect to be married before fellowship becomes active?.....

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 International Health Division of the Rockefeller Foundation must be submitted)

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

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

**TRAINING:**

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

**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 study?.....

When do you wish to begin your studies, 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 375, 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.)



**AGREEMENT**

Date.....

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

Signature.....

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**EMERGENCY ADDRESSES:** (Give names of nearest relatives or other emergency addresses. The first individual named will be notified by cable of your arrival at place of study.)

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

Address .....

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

Address .....

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

Address .....





Place.....

Date.....

The Rockefeller Foundation  
International Health Division  
61 Broadway, New York

This is to give assurance that

Doctor.....

Present position.....

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

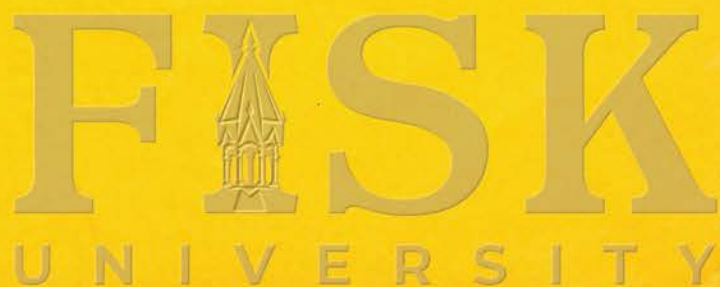
at the termination of his fellowship, should one be granted him, will be given the  
position of.....

.....  
.....

Signature .....

Title or Position .....

Official Address .....



THE ROCKEFELLER FOUNDATION  
INTERNATIONAL HEALTH DIVISION  
MEDICAL EXAMINATION

Name:

Candidate for { Fellowship  
                          } Staff Appointment

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)

(a) Tuberculosis

(f) Malaria

(b) Cardiac disease

(g) Acute or chronic respiratory diseases:

Sinus infections

(c) Gastro-intestinal disorders:

Tonsillitis

Appendicitis

Hay fever

Gallstones

Dysentery

(h) When was applicant last successfully vaccinated?

(d) Mental or nervous disabilities

(i) Has applicant had typhoid fever or antityphoid inoculation?           When?

(e) Arthritis

(j) Any disease or injury not mentioned above?

(e-1) 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

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



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.....