UCEAP UNIVERSITY OF CALIFORNIA EDUCATION ABROAD PROGRAM

Health Clearance Form

Student First and Last Name | UC Campus

UCEAP Program Country/Countries | Program Title | Partner/Host University | Term | ☐ Multi-city

HEALTH CARE PROVIDERS must be licensed to practice and cannot be an immediate family member. ***AMA Code of Ethics E-8.19***

Check either 1 or 2 in the appropriate box below. Only disclose information that is necessary and relevant to UCEAP's health clearance process.

I have reviewed the student's self-reported health history and available medical records. Based on the information provided to me by the student, a review of their available medical records, specialist recommendations provided (if applicable), and knowledge of the student's UCEAP program destination, to the best of my knowledge, the student is:

Licensed SPECIALIST or PSYCHOTHERAPIST
Section and signature only required if student is being treated by one.

1. ☐ **CLEARED** (Check all that apply below)
   - ☐ 1.a No medical or psychiatric contraindications to UCEAP participation.
   - ☐ 1.b Student advised to arrange services to facilitate education (e.g., note-taking, wheelchair access). A letter from the UC disability services office documenting the disability and indicating who will pay for services is required.
   - ☐ 1.c Student strongly advised to continue treatment abroad. (e.g., counseling, medical monitoring)
     - ☐ Student has a treatment plan.
     - ☐ Student is stable.
   - ☐ 1.d Student advised to find out if medication (or appropriate substitute) is locally available. Student advised to carry a sufficient supply to last through entire program (if allowed by customs).
   - ☐ 1.e Additional details attached in a separate letter regarding student's condition.

2. ☐ **NOT CLEARED:** There are **medical or psychiatric contraindications** to UCEAP participation.

Licensed Specialist: *Print name and credentials.*

Signature:

Date: Phone number:

Licensed GENERAL PRACTITIONER (MD, DO, NP, RN, or PA)
Section and signature required for ***all students****.*

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2. ☐ **NOT CLEARED:** There are **medical or psychiatric contraindications** to UCEAP participation.

Licensed General Practitioner: *Print name and credentials.*

Signature:

Date: Phone number:

CLEARING PRACTITIONER RUBBER STAMP OR BUSINESS CARD HERE:

Submit the completed form by either eFax or email by the deadline stipulated in the UCEAP Portal.

eFax (805) 893 3021 *This is a secure, HIPAA-compliant eFax portal.*

Email **healthclearance@uceap.universityofcalifornia.edu**
NOTE: Using non-encrypted email to send your completed health clearance is not private or secure. Also, there is a possibility that the email could be intercepted and read by others whom you did not intend to receive it.