PART III HEALTH HISTORY

INTERNATIONAL APPLICANTS ONLY

Last Name:	First Name:		MI:
Address:	City:	SSN: _____-_____-_____	
State/Province/Region:	Postal/Zip Code:	Country:	
Cell Phone:	Birth Date: (mm/dd/yy)		Age:
Home Phone:	Email :	Gender: ☐ Male ☐ Female	

TUBERCULOSIS TEST – To be completed by a physician

Check appropriate box:

1. PPD (Mantoux or Tine) test within the past two years (monovac not acceptable).

Result:	☐ Positive	☐ Negative	_____-_____
Result:	☐ Positive	☐ Negative	_____-_____

2. If the above is positive then the chest x-ray is required. Give date and result of chest x-ray.

Result:	☐ Positive	☐ Negative	_____-_____
Result:	☐ Positive	☐ Negative	_____-_____

Please provide medical facility verification stamp in the box above.

PHYSICIAN INFORMATION:

Medical Facility:	Phone:
Email:	Website:

_____ _____

Physician's Signature Date

Please return this form to: Christ For The Nations Institute * Attn: Enrollment Services Office* P. O. Box 769000 Dallas, TX 75376-9000