Anglican Diocese of the Western Gulf Coast

Dear Doctor,

This patient is a candidate for ordination in the Diocese of the Western Gulf Coast. You are being asked to provide him/her with a physical evaluation. The candidate is responsible for, and will arrange with your office, payment for the services.

As part of the ordination process, each candidate undergoes an evaluation by a licensed medical doctor who can provide an assessment of the candidate's physical health as it relates to the vocational demands of ordained pastoral ministry. Your assessment of the candidate is part of the overall process of discerning their preparedness for ordination.

At the appointment, please provide the candidate for ordination with a release waiver to sign so that you are able to share your written, confidential evaluation with the Diocese of the Western Gulf Coast. A waiver has been included if you prefer to use.

We ask that you please complete the attached Medical Evaluation Form and have your office return it directly to:

By mail:
Anglican Diocese of the Western Gulf Coast
HopePointe Anglican Church Campus
3333 So. Panther Creek Drive
The Woodlands, TX 77381
Attn: Credentialing Registrar

By email:
sandy@dwgc.org

Thank you for your service.

The Credentialing Office of the
Diocese of the Western Gulf Coast

AUTHORIZATION TO RELEASE INFORMATION

1. I am voluntarily seeking ordination in the Diocese of the Western Gulf Coast and I understand that part of the ordination process requires me to undergo a medical/physical assessment by a licensed medical doctor to evluate my medical/physical health.

2. I consent to participate in the assessment and understand that I may be asked questions related, but not limited to, family history, medical history, lifestyle habits, criminal history, marital history, and sexual behavior. I agree that all the information I provide will be truthful and not misleading.

3. I authorize the doctor to release a confidential written report to the Anglican Diocese of the Western Gulf Coast, Credentialing Registrar.

4. I authorize the doctor to discuss, either in written form or orally, the written report with either the Bishop or a member of Credentialing.

Applicant's Signature

Date

Applicant's Name (Please print)

MEDICAL EVALUATION FORM

When completed by the clinician, this report is sent to Diocesan Credentialing and remains in the applicant's permanent file. It may be shared with other canonically established bodies involved in the ordination process.

MAIL TO:
Anglican Diocese of the Western Gulf Coast
HopePointe Anglican Church Campus
3333 So. Panther Creek Dr.
The Woodlands, TX 77381
ATTN: CREDENTIALING REGISTRAR

EMAIL TO:
sandy@dwgc.org

Name of Applicant: _____

Date and Length of Examination: _____

MEDICAL EXAMINATION

Name	Date of Birth
Your Home Address	Phone Number/Fax Number
Marital Status	Children and Ages
Notify in Case of Illness	Phone Number/Fax Number

Personal Physician	Physician's Address	Phone Number/Fax Number

Please answer all questions below "Yes" or "No,"
provide full details in the space provided for any questions answered "Yes"

Have You	Yes	No
1. Ever been rejected or paid extra money for insurance:	☐	☐
2. Ever received Workmen's Compensation or other disability benefits?	☐	☐
3. Been rejected for employment on account of any physical or mental condition?	☐	☐
4. Ever received prescription drugs for mental illness or substance abuse?	☐	☐
5. Ever been a patient in a hospital?	☐	☐
6. Had any accidents, injuries oroperations or contemplate any operation?	☐	☐
7. Received disability benefits or medical leave for medical/psychiatric condition?	☐	☐
8. Had your medical or psychiatric fitness for a job or education studies questioned by a supervisor or a supervising institution?	☐	☐
9. Ever left school or any position because of ill health?	☐	☐
10. Lost time from work or school in the past three years for medical reasons?	☐	☐

Provide *full details* here for all questions answered "Yes". *Full details* include the condition, dates durations. List the question number when answering. Use additional sheets if necessary.

Significant Medical Conditions (✔)

	Yes	No	If Yes, Explain
Allergies	☐	☐	_____
Asthma	☐	☐	_____
Cardiac	☐	☐	_____
Chemical Dependency			
Drugs	☐	☐	_____
Alcohol	☐	☐	_____
Diabetes Mellitus	☐	☐	_____
Gastrointestinal Disorder	☐	☐	_____
Hearing Disorder	☐	☐	_____
Hypertension	☐	☐	_____
Neuromuscular Disorder	☐	☐	_____
Orthopedic Condition	☐	☐	_____
Respiratory Illness	☐	☐	_____
Seizure Disorder	☐	☐	_____
Skin Disorder	☐	☐	_____
Vision Disorder	☐	☐	_____
Other (Specify)	☐	☐	_____

Report of Physical Examination (✔)

	Normal	Abnormal	If Abnormal, Explain
Height (inches)	☐	☐	
Weight (pounds)	☐	☐	
Pulse ( )	☐	☐	
Blood Pressure /	☐	☐	
Hair/Scalp	☐	☐	
Skin	☐	☐	
Eyes-visual Acuity R / L /	☐	☐	
Eyes - Color Vision	☐	☐	
Ears - Hearing dB R L	☐	☐	
Nose & Throat	☐	☐	
Teeth & Gingiva	☐	☐	
Lymph Glands	☐	☐	
Heart - Murmur, etc.	☐	☐	
Lung - Adventious Findings	☐	☐	
Abdomen	☐	☐	
Genitalia	☐	☐	
Neuromuscular System	☐	☐	
Extremities	☐	☐	
Spine (Presence of Scoliosis)	☐	☐	

Signature of Examiner

Date of Examination

Print Name of Examiner

Address