THE UNITED METHODIST CHURCH

MEDICAL SUMMARY REPORT OF MINISTERIAL CANDIDATE

Form 103

Candidate's Name: _____

To the Board of Ordained Ministry:

Please indicate here, the name/address of the board officer who will receive this report.

Name: _____

Address: _____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION — COMPLETED BY CANDIDATE

Candidate Name: _____ Birth Date: _____

I hereby authorize and direct (physician) to disclose to the _____

_____ (annual conference) Board of Ordained Ministry the following information with regard to the records of _____ (candidate) for the purpose of evaluation by The United Methodist Church for entrance into ministry.

Release: I hereby release, indemnify, and hold harmless the (annual conference) Board of Ordained Ministry from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. This release includes any and all claims, damages, liabilities, or costs that may arise from the use or disclosure of the information provided.

Voluntary Consent: I have read and fully understand this consent form and the purpose for which my medical records will be used. My consent is voluntary. I acknowledge that I am not under any pressure or duress to provide this consent.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent will expire sixty (60) days after the date treatment is terminated unless another date is specified. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to disclosures that were made prior to receipt of my revocation.

I understand that the information requested may be disclosed from records whose confidentiality is otherwise protected by federal as well as state law. Any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders, as well as HIV status.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____

Signature of Candidate Date

_____ _____

Witness Date

SUMMARY REPORT – COMPLETED BY PHYSICIAN

Comments for physician:

Complete the summary report. The United Methodist Church assumes you are completing this information based on a current physical examination of the candidate. Screening guidelines are provided for reference as needed.

This person is a candidate for ministry in The United Methodist Church. Among other requirements, this includes being able to typically work a full-time week – with periodic weeks requiring longer work hours. Those serving in ministry will encounter situations that require the ability to cope with conflict and stress. Job-related tasks range from office work and traveling from site to site to communicating with and relating to a variety of people and managing multiple tasks simultaneously, among other responsibilities.

Candidate's Name: _____

Date of Physical Exam: _____

Check One:

___ Based on the physical exam I completed, this candidate appears to be healthy. I have no concerns about his/her physical fitness for ministry.

___ Based on the physical exam I completed, this candidate has some health concerns that are summarized below.

Summary of Concerns:

_____

_____

_____

_____

_____

Typical treatment(s) for this condition could potentially include (medication, surgery, lifestyle modification, intervention by specialist, frequent monitoring, etc.):

_____

_____

_____

_____

Questions to ask, or conversation that a committee might have, to address these concerns could include:

_____

_____

_____

_____

_____

Examining Provider: _____

Address: _____

_____

Phone: _____

Fax: _____

_____ _____

Signature: Date:

STAMP