

**WESTERN NORTH CAROLINA ANNUAL CONFERENCE**

**THE UNITED METHODIST CHURCH**

**BOARD OF ORDAINED MINISTRY**

Kimberly (Kim) T. Ingram, Registrar  
P.O. Box 18005, Charlotte, NC 28218-0005  
Phone 704-535-2260 N.C. WATS 800-562-7929  
Fax 704-567-6117 e-mail: [kingram@wnccumc.org](mailto:kingram@wnccumc.org)

---

**TO: EXAMINING PHYSICIAN**

The attached form is used by the Board of Ordained Ministry of the Western North Carolina Annual Conference for evaluating the health of those who are applying to become clergy persons in affiliation with the conference.

Our church requires that each clergy candidate must “present a satisfactory certificate of good health.”

As examining physician, you should determine the tests (lab tests, EKG, X-rays, etc.) which may be required to certify that the candidate is in reasonably good health. The conference makes no specific requirements in that regard.

If there are any questions, please call or write the registrar of the board at the address/ phone numbers shown above.

WESTERN NORTH CAROLINA ANNUAL CONFERENCE  
THE UNITED METHODIST CHURCH

**MEDICAL REPORT OF MINISTERIAL CANDIDATE**

**Part I. MEDICAL HISTORY REPORT**

(To be completed by the candidate)

Full Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Marital Status \_\_\_\_\_ Number of children \_\_\_\_\_

1. Check if you have ever had:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Tuberculosis

2. Check if any member of your family has ever had:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Poliomyelitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Tuberculosis

Explain: \_\_\_\_\_  
\_\_\_\_\_

3. What vaccinations or inoculations have you had? Give dates: \_\_\_\_\_  
\_\_\_\_\_

4. Have you ever had an electrocardiogram? If so, give date and attending physician: \_\_\_\_\_  
\_\_\_\_\_

5. Have you ever had a serious accident or operation? Explain \_\_\_\_\_  
\_\_\_\_\_

6. Have you any impairment of sight? \_\_\_\_\_ Hearing? \_\_\_\_\_

7. If your weight has changed in the past two years, state approximate loss \_\_\_\_\_ or gain \_\_\_\_\_

8. Have you ever been rejected for life insurance? \_\_\_\_\_ If so, why? \_\_\_\_\_

9. Have you ever received treatment for alcohol or drug habit? \_\_\_\_\_

10. Do you smoke? \_\_\_\_\_ For how long? \_\_\_\_\_ How much? \_\_\_\_\_

11. Have you ever been under observation or treatment in any hospital or sanitarium for a physical or nervous condition?  
Explain \_\_\_\_\_

**The statements made above are true and accurate to the best of my knowledge.**

Signature of Candidate \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

**Part II. MEDICAL EXAMINER'S REPORT**

(To be completed by the physician)

- 1. General Appearance \_\_\_\_\_
- 2. Personal Hygiene \_\_\_\_\_
- 3. Height \_\_\_\_\_ Weight \_\_\_\_\_
- 4. Temperature \_\_\_\_\_; Pulse before exercise \_\_\_\_\_, after \_\_\_\_\_;  
Blood Pressure before exercise \_\_\_\_\_; after \_\_\_\_\_
- 5. Vision \_\_\_\_\_
- 6. Hearing \_\_\_\_\_
- 7. Condition of mouth and throat:  
Pharynx \_\_\_\_\_ Tonsils \_\_\_\_\_  
Mucous membranes \_\_\_\_\_ Teeth \_\_\_\_\_  
Tongue \_\_\_\_\_ Gums \_\_\_\_\_
- 8. Evidence of goiter, enlarged glands, or other tumors \_\_\_\_\_
- 9. Evidence of varicosity \_\_\_\_\_ Hernia \_\_\_\_\_
- 10. Evidence of disease or abnormalities of:  
Heart \_\_\_\_\_  
Lungs \_\_\_\_\_  
Thorax \_\_\_\_\_  
Spine \_\_\_\_\_  
Genitalia \_\_\_\_\_
- 11. Evaluate nervous and mental condition \_\_\_\_\_

Test results (at discretion of physician):

- Urine \_\_\_\_\_ Chest X-ray \_\_\_\_\_
- Complete blood count (hemoglobin, MCV, white count) \_\_\_\_\_
- Pap smear \_\_\_\_\_ Mammogram \_\_\_\_\_
- Electrocardiogram (base line EKG) \_\_\_\_\_
- PSA (males over age 50) \_\_\_\_\_
- Cholesterol \_\_\_\_\_
- Other \_\_\_\_\_

**Summary of Findings and Recommendations**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return completed form to:

Rev. Kim T. Ingram Registrar  
WNCC Board of Ordained Ministry  
P.O. Box 18005  
Charlotte, NC 28218-0005

Name of physician \_\_\_\_\_  
(Please type or print)

Signature of physician \_\_\_\_\_

Address \_\_\_\_\_  
Date \_\_\_\_/\_\_\_\_/20\_\_