MOST WORSHIPFUL PRINCE HALL GRAND LODGE, F. & A.M.
OF THE STATE OF MISSOURI AND JURISDICTION

MEDICAL CERTIFICATE

Date: _____

Candidate Name *(print)*: _____ Age: _____
First *Middle* *Last*
Phone: _____
Address: _____ City: _____ State: _____Zip: _____
Application for membership in _____ Lodge, No. ____
Located at _____ Occupation: _____
Marital Status: Single _____ Married _____ Number of children: _____

STATEMENT TO MEDICAL EXAMINER
(To be completed by candidate)

PERSONAL HISTORY:

Have you ever used habit forming drugs or been treated for any drug or alcohol habit? _____
Have you ever applied for Life, Accident or Health Insurance or for membership in this or any other Fraternal Organization and been rejected? _____
To the best of your knowledge have you ever been treated for any of the following diseases, answer yes or no? If yes, give details in remarks:

	Yes	No	Describe, if Yes
A. Head or Neck disorders or Operations			
B. Diseases of the Lungs			
C. Heart Disease			
D. Diseases of the Circulatory System			
E. Disorders of the Digestive System			
F. Diseases of the Genitourinary System			
G. Diseases of the Muscle, Bones or Joints			
H. Diseases of the Nervous System			
I. Cancer			
J. Tumors			
K. Operations:			Type/When:

When did you last consult a Physician? _____
For what ailment? _____
Name of Physician. _____
Address: _____ City _____ State _____ Zip_____
Remarks: _____

I certify that all the statements and answers above are true, and should any prove to be otherwise, I hereby agree to forfeit all benefits that may have been granted on the strength of such statements or answers.

_____
Candidate's Signature

Name: _____ Date of Birth: _____

STATEMENT OF MEDICAL EXAMINER
Physician Examination

Pulse_____ Respiration_____ B.P. Systolic ____Diastolic____ HGT____ WGT___	
General Appearance	
Head	
Eyes	
Ears	
Nose	
Throat	
Neck	
Chest	
Lungs	
Heart	
Abdomen	
Back and Spine	
Genitals	
Hernia	
Extremities	

Remarks:

_____

_____

_____

Signed _____M.D. Date _____
Local Medical Examiner

Physicians Name (Printed or Typed) Address, City, State & Zip

_____ _____

Date
Received this _____month, ____day of _____year

Approved ____ Rejected _____ Grand Medical Examiner _____
(Signature)