Name (please print) Last First Date of Birth

Address City State Zip Phone (cell or home)

PLEASE CHECK THE APPROPRIATE PROGRAM

□ ADN □ MLT □ RTT □ LPN □ MT □ RADT □ HIMT

HT (in.)	WT (lbs.)	PULSE:	RESP:	BP:

ALLERGIES:	CURRENT MEDS:
MEDICAL HX:	SURGICAL HX:

	NORMAL	ABNORMAL	COMMENTS
APPEARANCE			
HEENT			
LYMPH NODES			
SKIN			
CHEST, BREASTS, LUNGS			
HEART			
ABDOMEN			
MUSCKULOSKELETAL			
NEURO			
PSYCH			

PHYSICAL ACTIVITY LIMITATIONS? YES _____ NO _____ If yes, explain ________________________________

Do you consider the applicant physically and emotionally able to undertake a program in the Health Sciences? YES ________ NO __________

Remarks:

Physician's Name (Please Print): ____

Office Address/phone number: ____

Physician's Signature ***Date of Examination***

RETURN TO STUDENT FOR DOCUMENT UPLOAD