EXSC / HHPF Internship

PHYSICAL EXAMINATION VERIFICATION

To Be Completed by Student *(Please Print)*

MUST BE COMPLETED WITHIN 12 MONTHS OF ENROLLMENT.

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DATE OF BIRTH (MM/DD/YEAR) _____

Do you have any health problems or concerns of which your provider should be aware?

☐ Yes ☐ No

If you wish to receive care for the above problems or concerns it is your responsibility to make a follow-up appointment and to provide copies of pertinent medical records as necessary.

Student Signature _____ Date _____

To Be Completed by Medical Provider (MD, DO, PA, NP)

A thorough history and physical examination were completed on the above named individual, with the following results:

☐ All findings were within normal limits. Student is capable to fulfill duties of an Internship.

☐ Follow-up care is required; patient was advised

_____

_____

_____

Medical Provider's Signature _____ Print Name _____ Date _____

Facility Name (*Please Print)* _____ Office Phone Number _____

Address _____ City & State _____ Zip Code _____

UPLOAD TO COURSE CANVAS PAGE 1 MONTH PRIOR TO SEMESTER START DATE