Campus Health Center
Nebraska Methodist College
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Omaha, NE 68114-3426

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PHYSICAL EXAMINATION

This form is to be completed by a primary health care provider (MD, NP, PA)

Name: _____ Program of study: _____

Date of birth: _____ Gender: _____

To certifying official: This individual has been accepted as a student at NMC and plans to attend one of our health science programs. During the learning program, this individual will be working with patients and may be vulnerable to certain health risks. Students are expected to perform the technical standards for their program as listed on www.methodistcollege.edu.

Date of Health Examination: _____

a. ____ I certify that I have completed a health examination of the above named individual within the past year and find the individual in good health and able to pursue any learning activities with high-risk health groups.

b. ____ I am indicating below if the individual examined has any health conditions NMC should know about. This will allow NMC to plan learning experiences accordingly.

_____

_____

_____

c. ___ I certify that I have completed a health examination of the above named individual within the past year and find the individual is **NOT** in good health and **UNABLE** to pursue any learning activities with high-risk groups.

Health Care Provider Name (Please print):_____ Date: _____

Provider signature: _____ Tel: _____

Office Address: _____ Fax: _____

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