



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