Part I: To be completed by Student:

Indicate program of application:	
☐ Associate Degree Nursing (RN)	☐ Medical Scribe
☐ Dental Hygiene (DH)	☐ Nursing Assistant/Home Health Assistant (NA/HHA)
☐ Health Information Technology (HIT)	☐ Pharmacy Technician
☐ Health Information Management (HIM)	☐ Physical Therapist Assistant
☐ Medical Assisting (MA)	☐ Vocational Nursing (LVN)

Applicant information:				
Last Name	First Name		MI	Maiden
Address	City		State	Zip
Email Address	Birth date	Gender ☐ M F ☐		
Phone (day)	Phone (eve)		Phone (cell)	

Person to notify in case of emergency:			
Full Name		Relationship	
Address – Number & Street	City	State	Zip
Home Phone	Work Phone	Cell	

HEALTH HISTORY

Please rate you current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Certain minimum physical abilities and characteristics are required in health sciences professions. Do you have any condition that would interfere with your ability to perform the minimum technical skills standards for the program to which you are applying?

☐ Yes ☐ No If yes, explain: _____

_____

Are you pregnant? ☐ Yes ☐ No If yes, due date: _____

Allergies/sensitivities (i.e. medications, foods, Latex/Powder): Please List: _____

_____

Do you have any lifting restrictions: ☐ Yes ☐ No If yes, explain: _____

_____

The information provided is true and correct to the best of my knowledge. I am aware that any change in my physical or mental health, including pregnancy, during the program may require that I obtain medical clearance to continue in the program.

Student Signature: _____ Date: _____

HEALTH DATA & PHYSICAL EXAM FORM (continued)
FOR HEALTH CARE OCCUPATIONS

Applicant Name:	Date:

Part II: To be completed by health care provider

☐ I have reviewed the student's Technical Standards Disclosure form

Does your examination of the student reveal any limitations in the following:			
SPINE: ☐ Yes or ☐ No	LIFTING: ☐ Yes or ☐ No	PROLONGED STANDING: ☐ Yes or ☐ No	
PROLONGED SITTING: ☐ Yes or ☐ No		BENDING: ☐ Yes or ☐ No	☐ **NO LIMITATIONS OF ANY TYPE**

Based upon today's subjective/objective exam and the disclosed health history, does this student have any health condition that would create a hazard to self or others, or limit their ability to provide health & patient care and/or services?

☐Yes ☐ No ☐ Any health condition is under observation and/or treatment and does not create a hazard

If yes, explain:

Physician or Approved Licensed Health Professional Information:	
Agency or Clinic providing service (*Name & Address or Facility Stamp*)	
Printed Name	Title
Signature	Date