

Part I: To be completed by Student:

Indicate program of application:	
<input type="checkbox"/> Associate Degree Nursing (RN) <input type="checkbox"/> Dental Hygiene (DH) <input type="checkbox"/> Health Information Technology (HIT) <input type="checkbox"/> Health Information Management (HIM) <input type="checkbox"/> Medical Assisting (MA)	<input type="checkbox"/> Medical Scribe <input type="checkbox"/> Nursing Assistant/Home Health Assistant (NA/HHA) <input type="checkbox"/> Pharmacy Technician <input type="checkbox"/> Physical Therapist Assistant <input type="checkbox"/> 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:
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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: <input type="checkbox"/> Yes or <input type="checkbox"/> No	LIFTING: <input type="checkbox"/> Yes or <input type="checkbox"/> No	PROLONGED STANDING: <input type="checkbox"/> Yes or <input type="checkbox"/> No	
PROLONGED SITTING: <input type="checkbox"/> Yes or <input type="checkbox"/> No	BENDING: <input type="checkbox"/> Yes or <input type="checkbox"/> No	<input type="checkbox"/> NO LIMITATIONS OF ANY TYPE	

Based upon today's exam (which includes all body systems) 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 <i>(Name & Address or Facility Stamp)</i>	
Printed Name	Title
Signature	Date