Date: ____________________________________

To Applicant: ______________________________

Thank you for your interest in the February 2020 – May 2021 (15 months) Paramedic course here at Randolph Community College. Required documentation prior to being able to register for the course are listed below:

_________In date/valid NC DMV Driver's License

_________Official copies of high school transcript or diploma/ GED and all college transcripts

_________Current NC EMT Certification must be complete prior to the start of clinical

_________Current AHA Health Care Provider BLS certification (this is offered during your course)

_________Reading comprehension, English language skills and Mathematical skills on the post-secondary level

- Placement into college level English and Math courses are required. (See attached documents for further details)

  ***********_**Placement score must be within the last 3 years**_ *****************

________Authorization for submission of Criminal Background Check and Drug Screen Test

________Completed and signed Scholarship Information Packet (if desired)

________Completed and signed physical from a physician with a shot record included. (See attached document for required immunizations).

*****************Anatomy and Physiology requirement must be met by the end of the first section. Randolph Community College does offer this course Online for EMS providers.

Please submit these items to the Continuing Education Office. If you have any questions, please contact 336-633-0268

Randolph Community College EMS Advanced Life Support Programs

Admission Requirements (Student must provide official documentation **PRIOR** to admission to the course)

- In Date/Valid NC DMV Driver's License
- Official copies of high school transcript and/or GED test scores and **all** college transcripts
- Current NC EMT Certification
- Current AHA Health Care Provider BLS Certification (will cover in class as well)
- Assessment for Reading, Writing and Math **(Those with post-secondary education will be required to provide official transcripts in order to opt out of Assessment Tests degree must have been obtained within the last 3 years**). **Visit the Student Success section on the website or call 336-633-0200**. Students who do not meet the cut scores on placement assessment(s) must complete and pass Developmental Studies courses with a grade of "C" or better **prior** to registering for the course.
- Student Medical form **properly and completely** filled out by a medical provider (NCCCS form)
- Authorization for submission of Criminal Background Check and Drug Screen Test
- Complete Immunization Records to include:
    - Tetanus Booster within 10 years
    - Tuberculosis baseline screening- Quantiferon or T-Spot blood test; or current documentation of 2 step PPD Skin Test or if positive history, a current QPPD (Tuberculosis Questionnaire)
    - MMR (measles, mumps and rubella) 2 documented vaccinations or positive titers for measles, mumps and rubella
    - Hepatitis B vaccine or a declination statement
    - Varicella-Positive serum titer or 2 documented Varivax Vaccines
    - Seasonal Flu vaccination (October 1st – March 31st)
- RCC's Health History Form and Immunization Policy and the Student Medical Form for NCCCS is included in this packet.

Please see a more detailed list of the required immunizations on the next two pages:

Certified Background Check and Drug Screen Instructions:

This must be completed at least 30 days prior to clinical start date!!!

The information to obtain your certified background check and drug screen will be given out on the first day or night of class. There is an additional cost for this and it is not included in the tuition. The fees will be paid directly to the agency. This fee is around $100.00

Class Location

- All classes and labs will be conducted at the Asheboro Campus of RCC in the CEIC Building. Classroom 104/109 until our new Allied Health Building ready.
- Clinical locations will vary throughout the area depending upon availability and student need.

Class Times

- Class/lab times will be determined pending enrollment. (Contact the Administrative Assistant at 336-633-0268 for more details)
- Clinical times will vary according to site availability and student need.

Course Charges for Part I Paramedic

Registration Part I Paramedic	$180.00 (if affiliated this fee is waived)
Student ID:	$0.55/year
Malpractice Insurance	$16.00/ policy year must be renewed
Accident Insurance	$0.55/ policy year must be renewed
AHA Fee	$35.00
Supply Fee	$150
Resource Fee	$182.50
Total Due at Registration	$564.60(less 180.00 if tuition exempt = $384.60)

Additional fees that are not included in the registration fee: (students will be responsible for the fees listed below). Also please be advised that the fees listed below are subject to change.

Certified Background (with drug screen)	~$ 100.00 (this is an estimate)
Books	~$ 600.00 (this is an estimate)
Uniforms	~$ 200.00 (this is an estimate)
	~$900.00 (this is an estimate)

Course Charges for Paramedic (Part II)

Registration Part II	$180.00 (if affiliated this fee is waived)
Malpractice Insurance	$16.00/ policy year
Accident Insurance	$0.55/policy year
Total due at Registration	$196.55(less 180.00 if tuition exempt = $16.55)

Textbooks:

Nancy Caroline's Emergency Care in the Streets 8th Edition (with Navigate 2 Advantage Access): ISBN 9781284457025 **or you can choose** the Nancy Caroline's Emergency Care in the Streets 8th Edition (with Navigate 2 Essentials Access): ISBN: 9781284104882 (The difference between the two books consist of available online resources and the cost. One book offers an eBook as well and the other offers an audio book).

Understanding EKGs, a practical approach 4th edition ISBN: 9780133389845

Understanding 12-Lead EKGs 3rd edition ISBN: 9780133108668

AHA BLS, ACLS, and PALS current textbooks (our AHA department currently have these books available for purchase)

Clinical/Field Internships

Students must have the ability to remain flexible and have reliable transportation. The

Clinical schedule varies from 6am to 11pm Monday – Sunday and will involve travel.

Reading, Writing and Math Assessments

All students must pass a reading, writing and math assessment or have records that indicate a proficiency in these subjects (within the past 3 years). The Assessment Verification form is included in this packet.

Uniform/Dress Code Requirements

Emergency Medical Services is a part of Public Safety and as such is a uniformed service. Students in the RCC EMS Paramedic program will be required to attend class and clinical internships wearing their approved uniform. The uniform will consist of the following:

- RCC EMS uniform shirt ~20.00 (must order from RCC campus store)
- RCC EMS uniform t-shirt ~10.00 (must order from RCC campus store)
- EMS style Cargo Pants ~35.00 and up (order/purchase on your own)
- Black leather or nylon duty belt ~15.00 (purchase on your own)
- Black EMS style uniform shoes or boots~50.00 and up (purchase on your own)
- Black socks ~5.00 (purchase on your own)
- Second-hand watch ~5.00 and up (purchase on your own)
- All weather jacket (black or navy blue) ~50.00 (purchase on your own)
- Reflective traffic vest ~15.00 (purchase on your own)

**** **All prices for items from outside vendors such as books, uniforms etc. are subject to change.**

Randolph Community College

Preliminary Application for Admission to the Paramedic Course

Academic Year 2020-2021

Personal Information (PLEASE PRINT)

____

Last Name First Name Middle Name

_____/_____/________ _____-____-______ ____________________

Date of Birth Social Security Number RCC Student ID (if known)

Address____

City___________________________ State_____________ Zip_______________

Phone (____)____________________ Cell (____) _________________

Email Address ____

Applications can be returned to Randolph Community College in the CEIC Building. Please mark "EMS Paramedic Program Attention: Kimberly Jeffries"

****Registration will be complete upon the receipt of this application with all required documents. Also, a completed registration form and the payment of all associated tuition and fees.**

RANDOLPH COMMUNITY COLLEGE
Emergency Medical Services Program

Reading, Writing, and Math Assessment Verification

Appointments are required for testing. Limited same day testing may be available.

Asheboro: Call (336) 633 – 0223 or (336) 633 – 0321

Archdale: Call (336) 862 - 7980

Appointments are available mornings, afternoons, and evenings

Location: Asheboro - Assessment Center (next to the greenhouses; behind the Campus Store)
Archdale –Main Building

Acceptable scores / courses (scores and courses must be less than 3 years old):

Reading & Writing:
- NCDAP (Accuplacer) – placement into English 111 (score of 151 or higher)
- Completion of a college-level English class (within last 3 years)
- CASAS (Form 907R or 908R) – score of 254 or higher
- TABE 9/10 – GE 12.9+ (9D – 622; 10D – 634; 9A – 617; 10A – 628)
- TABE 11/12 (Level D or A) – score of 710 or higher

Math:
- NCDAP (Accuplacer) – score of 7 or higher on each DMA 010 / 020 / 030
- Completion of DMA 010 / 020 / 030 with a passing grade in each
- Completion of MAT 060 or any college Algebra course (within last 3 years)
- TABE 9/10 Math – GE 12.9+ (9D – 617; 10D – 618; 9A – 618; 10A – 617)
- TABE 11/12 Math (Level D or A) – score of 730 or higher

If any diploma, GED, college degree or placement score is older than three (3) years the student must complete any required entrance exams with the required score prior to registering for the desired course.

If a student wishes to submit scores from another institution, please see the Welcome Center to have those scores transferred officially to RCC as a print-out of the scores will not be accepted.

Randolph Community College

Information regarding Criminal Background Check/Drug Screen/Externship for Potential Students

Do NOT obtain this background check or drug screening prior to starting the Course. You are simply signing this form acknowledging that you have been made of this requirement. During the course Orientation additional information with instructions on how to obtain both will be provided. .

Paramedic

All potential student in health occupations programs should be aware that our clinical agencies require the student to complete a national criminal background check and drug screen prior to being allowed into the clinical setting. Specifically, these policies may exclude persons with felony convictions and certain misdemeanor convictions from participating in clinical education at their facility.

Potential students should be aware that this will be their financial responsibility.

My signature below indicates that I am aware of the information regarding the National criminal background check and drug screen being required for entry into clinical facilities. I understand that if I fail to meet certain criteria, as set by these facilities, that I may not be able to participate in clinical education and that this may prevent my successful completion of the program to which I am applying.

______________________________ ____________________

Signature Date

______________________________ ____________________

Misc.	Date
Criminal Background Check	
Urine Drug Screen	

Immunizations	Date
Flu (seasonal)	
MMR	Date
▪ 1st	
▪ 2nd	
▪ titer	
Varicella (Chickenpox)	Date
▪ 1st	
▪ 2nd	
▪ titer	
Tetanus/ Diphtheria (Tdap) (within the last 10 years)	Date
Polio	
▪ Attended K-12 in US	Yes No

Tuberculosis	Date
▪ PPD #1	
Tuberculosis	Date
• PPD #2	
Hepatitis B Vaccine (HBV)	
▪ 1st	
▪ 2nd	
▪ 3rd	
▪ Titer	
▪ waiver	

*Varicella history of the disease is no longer acceptable. Medical students are required to have a documented serology. If serology result is negative, students must also provide documentation of two (2) doses of Varicella vaccine.

*Influenza is required from October 1st through March 31st

Tuberculosis Baseline Screening:

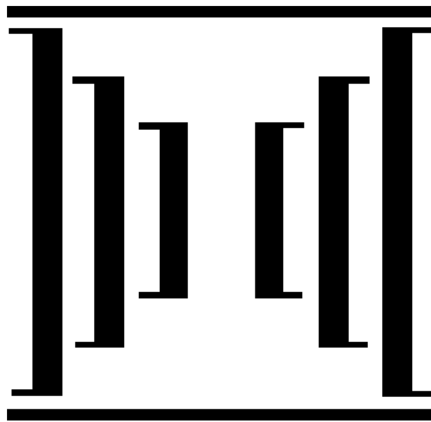
- Quantiferon (preferred method for Wake Forest)

- T-spot blood test (preferred method for Wake Forest

- Or skin test done within the last 14 months. An additional TB skin test done within 60 days of start of clinical. Must have a minimum of 7 days between 1st TB skin test administered and the 2nd. If you have tested positive for TB in the past, you must provide a copy of TB skin test with mm measurement at the time of testing positive for TB or positive IGRA report. Chest x-ray with report must be done within 60 days of start date and any treatment documentation.

Student's Printed Name:________________________ Signed Name: _____________________________

Student Medical Form for North Carolina Community College System Institutions



Please return this completed form to: Randolph Community College
Attention: EMS Department
629 Industrial Park Ave.
Asheboro, NC 27205

Randolph Community College

(336) 633-0200 www.randolph.edu

Revised 2018

REPORT OF MEDICAL HISTORY *(Please print in black ink)* *To be completed by student*

LAST NAME (print) FIRST NAME MIDDLE/MAIDEN NAME LAST 4 DIGITS SOCIAL SECURITY NUMBER

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

DATE OF BIRTH (mo/day/yr)________________ GENDER ☐ M ☐ F MARITAL STATUS ☐ S ☐ M ☐ OTHER EMAIL____________________

HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)

NAME OF POLICY HOLDER EMPLOYER

IS THIS AN HMO/PPO/MANAGED CARE PLAN? ☐ YES ☐ NO

POLICY OR CERTIFICATE NUMBER GROUP NUMBER

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP (MUST NOT BE BOYFRIEND/GIRLFRIEND/FIANCE/FRIEND)

ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

Is it Ok to contact above person in the event of an emergency? YES______NO ________

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. *Please attach additional sheets for any items that require fuller explanation.*

FAMILY & PERSONAL HEALTH HISTORY *(Please print in black ink)* *To be completed by student*

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
High blood pressure			
Stroke			
Heart attack before age 55			
Blood or clotting disorder			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			

	Yes	No	Relationship
Cancer (type):			
Alcohol/drug problems			
Psychiatric illness			
Suicide			
Other (Specify)			

HEIGHT______________________ WEIGHT ____________________

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year
High blood pressure			
Rheumatic fever			
Heart trouble			
Pain or pressure in chest			
Shortness of breath			
Asthma			
Pneumonia			
Chronic cough			
Head or neck radiation treatments			
Tumor or cancer (specify)			
Malaria			
Thyroid trouble			
Diabetes			
Serious skin disease			
Mononucleosis			

	Yes	No	Year
Hay fever			
Allergy injection therapy			
Arthritis			
Concussion			
Frequent or severe headache			
Dizziness or fainting spells			
Severe head injury			
Paralysis			
Disabling depression			
Excessive worry or anxiety			
Ulcer (duodenal or stomach)			
Intestinal trouble			
Pilonidal cyst			
Frequent vomiting			
Gall bladder trouble or gallstones			

	Yes	No	Year
Jaundice or hepatitis			
Rectal disease			
Severe or recurrent abdominal pain			
Hernia			
Easy fatigability			
Anemia or Sickle Cell Anemia			
Eye trouble besides need glasses			
Bone, joint, or other deformity			
Knee problems			
Recurrent back pain			
Neck injury			
Back injury			
Broken bone (specify)			
Kidney infection			
Bladder infection			

	Yes	No	Year
Kidney stones			
Protein or blood in urine			
Hearing loss			
Sinusitis			
Severe menstrual cramps			
Irregular periods			
Sexually transmitted			
Blood transfusion			
Alcohol use			
Drug use			
Anorexia/Bulimia			
Smoke 1+ pack cigarettes/week			
Regularly exercise			
Wear seat belt			
Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name_________________________Use_______________Dosage____________Name_________________________Use________________Dosage______________

Name_________________________Use_______________Dosage____________Name_________________________Use________________Dosage______________

Name_________________________Use_______________Dosage____________Name_________________________Use________________Dosage______________

Name_________________________Use_______________Dosage____________Name_________________________Use________________Dosage ______________

FAMILY & PERSONAL HEALTH HISTORY-CONTINUED *(Please print in black ink) To be completed by student*

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions to:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			

	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Is there loss or seriously impaired function of any paired organs? (Please describe)			
Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION…. PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT /GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. **(Not applicable to community colleges.)**

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. **(Not applicable to community colleges.)**

______________________________ ________________
Signature of Student **Date**

______________________________ ________________
Signature of Parent/Guardian, if student under age 18 **Date**

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD AND TB SCREENING

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Please review information noted in each section prior to entering information in sections A, B, and C.

Acceptable Records of Your Immunizations May be Obtained from Any of the Following: (Be certain that your name date of birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. **Keep a copy for your records.**)

- High School/Previous College/University Records – These may contain some, but not all of your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
- Personal Shot Records – Must be verified by a doctor's signature or by a clinic or health department stamp, including a printout from any Immunizations Registry.
- Military Records or WHO (World Health Organization Documents)

SECTION A:	**IMMUNIZATION REQUIREMENTS ACCORDING TO AGE**			
STUDENTS 17 YEARS OF AGE AND YOUNGER				
Tdap	Polio	Measles[2]	Mumps[4]	Rubella[4]
Every 10 years	3	2	1	1
STUDENTS BORN IN 1957 OR LATER AND 18 YEARS OF AGE OR OLDER				
Tdap	Polio	Measles[2,3]	Mumps[4]	Rubella[4]
Every 10 years	0	2	1	1
STUDENTS BORN BEFORE 1957				
Tdap	Polio	Measles	Mumps	Rubella[4]
Every 10 years	0	0	0	1
STUDENTS 50 YEARS OF AGE AND OLDER				
Tdap	Polio	Measles	Mumps	Rubella
Every 10 years	0	0	0	0
INTERNATIONAL STUDENTS				
Vaccine Required				
Vaccines are required according to age (refer to appropriate box). Additionally, students are required to have two TB skin tests with negative results within the 12 months preceding the first day of classes (chest x-ray required if test is positive).				

1. DTP (Diphtheria, Tetanus, Pertussis): One Tdap (Diphtheria, Tetanus, Pertussis) within the last ten years
2. Measles: One dose on or after 12 months of age; second at least 30 days later. Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.
3. Two measles doses if entering college for the first time after July 1, 1994.
4. One dose on or after 12 months of age. Only laboratory proof of immunity to rubella or mumps disease is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

SCREENING/DIAGNOSTIC TESTS:

TB Skin Tests: 2 tests performed within the last year (administered and read by a nurse, NP, PA, or physician). Must read 0 mm or No Induration. Quantiferon Gold (If accepted by admitting program) must show numeric result. If positive result from TB Skin Test or Quanitferon Gold, chest x-ray is required and must be updated every year while in the admitting program. Results of chest x-ray must be documented by doctor and submitted for admission and progression in the program.

SECTION B:	These vaccines are **RECOMMENDED** Some may be required by certain departments. Consult your college or department for specific requirements.

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on page 6 of this form, whether or not you have received the meningococcal vaccine. If **yes**, please note the month, day, and year of the vaccination.

SECTION C:	These vaccines are **OPTIONAL**.

IMMUNIZATION RECORD	**(Please print in black ink) To be completed and signed by physician. A complete immunization record from a physician should be attached to this form.**				
Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	Last 4 Digits of Social Security Number	

.

SECTION A REQUIRED IMMUNIZATIONS AND TB SCREENING (DO NOT WRITE IN SHADED AREAS)				
	mo./day/ year	mo./day/ year	mo./day/ year	Titer Date, Numeric Result, and Range of Immunity
	(#1)	(#2)	(#3)	
• Tdap				
• MMR (after first birthday) Series of 2 vaccinations or immunity by positive blood titer for each of the below components				
• MR (after first birthday)				
• Measles (after first birthday)				
• Mumps				
• Rubella				
• Hepatitis B series only (series of 3 vaccinations or immunity by positive blood titer				
• Varicella (chicken pox) series of two doses or immunity by positive blood titer				
• Tuberculin (PPD) Test (2 tests within 12 months) Date read mm induration				
• Quantiferon Gold Titer				
Chest x-ray, if positive PPD • Attach results report Attach Results				
• Treatment if applicable Date				
• Influenza (Current Season)				

SECTION B: Recommended Immunizations

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Meningococcal	Received the meningococcal vaccine? **No** ☐ **Yes** ☐
If **Yes**, please indicate date(s) vaccine was received (mo./day/year)	

SECTION C OPTIONAL IMMUNIZATIONS			
	mo./day/year	mo./day/year	mo./day/year
• Haemophilus influenzae type b			
• Pneumococcal			
• Hepatitis A series only			

Signature/Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

Office Address **City** **State** **Zip Code**

** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

**** Attach Lab report

PHYSICAL EXAMINATION *(Please print in black ink)* *To be completed and **signed** by physician*

A physical examination is required. It must be completed in black ink and signed by a physician.

Last Name First Name Middle Name	Date of Birth (mo/day/year)	Last 4 Digits of Social Security Number

Permanent Address City State Zip Code	Area Code/Phone Number

Height___________ Weight___________ TPR___________/_________/___________ BP_________/_______

ALL SECTIONS REQUIRED:	**ALL SECTIONS REQUIRED:**
Vision: Corrected Right 20/_______Left 20/ ________	Hearing: (gross) Right__________ Left__________
Uncorrected Right 20/_______Left 20/ ________	15 ft. Right__________ Left __________
Color Vision ______________________________	

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? Yes_________ No __________
Explain ____

B. Is student under treatment for any medical or emotional condition? Yes_________ No __________
Explain ____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited_________ Limited__________
Explain ____

D. Is student physically and emotionally healthy? Yes_________ No ________
Explain ____

• REQUIRED FOR ALL STUDENTS •

Based on my assessment of this student's physical and emotional health on______________________________ (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_________No________if no, please explain __________

______________________________________ ______________________________
Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

______________________________________ ______________________________
Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

____
Office Address **City** **State** **Zip Code**