Allied Health Programs
Physician's Health Verification form

Student's Name:_____ Training Program:_____

PHYSICIAN'S OFFICE MUST COMPLETE THIS FORM

The above named student was seen by me on _____ (Date).

Physician's name: _____

Address:_____

Phone number: _____

Facility Stamp

At this time, there is no indication this student has a communicable disease or health condition That would create a hazard to themselves, classmates, or patients. The student is able to meet the minimum physical standards of the allied health program noted above, which includes at a minimum: performing repetitive manual movements, ability to lift 50+ lbs, and bladder control and ability to stand for 4+ hours at a time.

My signature below indicates agreement with the above statement.

Physician's Signature: _____ (Required – Original or Electronic Accepted)

Physician's Office Must Complete the Following

1. **Tuberculosis (TB) Clearance:** Date_____ Result_____ **(Chest X-Ray is required for pos. results)**

   Check the type of TB test given: ☐ PPD ☐ Quantiferon ☐ Chest X-Ray

2. **Influenza Vaccination:** Date:_____ Or sign declaration form.
   Required when attending the program for clinical externship between September and April.

3. **COVID-19 (Recommended)*** Vaccination Date(s): 1st_____ 2nd _____ Booster_____

   Check Type: ☐ Moderna ☐ Pfizer ☐ J&J Or sign declination form.