College of Nursing
3800 Victory Parkway
Cincinnati, OH 45207-7351
513 745-3814

PHYSICAL EXAMINATION FORM

STUDENT: COMPLETE THIS SECTION

I understand that a certification of physical health is required in order to attend clinical courses and that if my health status changes such that restrictions are required for clinicals, I must notify the College of Nursing and provide appropriate documentation as outlined in the nursing student handbook under compromised or altered health status. Annually thereafter, I will submit Page 2 to verify my health status for clinicals and will notify the College of Nursing if changes at any other time.

I understand that I am not permitted in the clinical area until this completed form and all other required documentation has been submitted as instructed. I will maintain documentation for my records. I understand that I may need to provide it for a future clinical experience/employer and that the College of Nursing is not responsible for providing it to me in the future.

Student signature _____ Date _____

Student printed name _____ DOB _____

HEALTH PROFESSIONAL: COMPLETE THIS SECTION

The student named above has had a complete physical examination and has:

____ no restrictions ____ restrictions – see attached information

Note to physician: If restrictions do exist, please attach explanation.

Date of this physical examination was: _____
Month Day Year

_____ _____ _____
Signature (physician/nurse practitioner verifying information) **Printed name** **Date signed**

NAME/ADDRESS/PHONE OF HEALTH CARE PROVIDER

_____

_____

_____

The healthcare provider signature and contact information must be provided or this form will be rejected.