



The
UNIVERSITY
of **VERMONT**

COLLEGE OF NURSING & HEALTH SCIENCES

Name _____
 Student ID # _____
 Date of Birth _____
 Program/Graduation Year _____
 Phone# _____
 Email _____
 Date _____

PHYSICAL EXAMINATION PRE-CLINICAL REQUIREMENT

COPIES OF MEDICAL RECORDS/LABS WILL NOT BE ACCEPTED.

PHYSICAL EXAMINATION

I affirm that this student had a physical examination on this date: _____

Licensed Health Care Provider Attestation

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being **unable to progress in his/her major** at the University of Vermont.

 Signature of **Licensed Health Care Provider** **Credentials** Date

 Clinic Stamp or Printed Name of Provider Provider Telephone Number

It is MANDATORY that you scan and upload this form to CastleBranch

Please note, UVM Student Health will not submit your paperwork for you. You will need to pick up your documents and submit them to CastleBranch.

The information included on this form maybe released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.