



UNIVERSITY OF ST. AUGUSTINE

FOR HEALTH SCIENCES

Clinical Education Department – Physical Form

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|--------------|--|
| Student Name | |
| Student DOB | |
| Date of Exam | |

Healthcare Provider Certification

I certify that I have performed a comprehensive physical exam on the above-named student and have found him/her to be in good health, free of communicable disease and able to perform the following essential functions, as required by the program:

1. Able to stand 30 minutes
2. Ability to climb stairs
3. Able to kneel, crawl, stoop
4. Able to bend backward and forward
5. Able to balance on one leg
6. Physically able to perform CPR
7. Able to view video or written word on screen

Healthcare Provider Signature

Date

Healthcare Provider Name and Address (please print)