[EMU Logo]

EMU Health Information Form EMU Health Services, 1200 Park Rd., H’burg, VA 22802

Phone: (540) 432-4308

**Upload Completed Form at** [**https://emu.medicatconnect.com/**](https://emu.medicatconnect.com/)

**FORMS ARE DUE by July 1st for fall registration and December 5th for spring registration. Failure to comply will result with a HOLD in your registration process.**

**INSTRUCTIONS**

* **Student** completes and signs Pages 1, 2 and 4. **Please print legibly.**
* **Health Care Provider** completes and signs Pages 3 [**Pg 3 & 5 for Athletes**]
* **Fall enrollment -** physical performed within the past year; **Performed** **AFTER May 15** for **Athletes**
* **Spring enrollment -** physical performed within the past year; **Performed AFTER** **Nov.** **15** for **Athletes**

**UPLOAD your COMPLETED Health Information form at** [**https://emu.medicatconnect.com/**](https://emu.medicatconnect.com/)

**(Please do not upload BLANK or INCOMPLETE pages.)**

**Name:** **EMU ID#:**

**LAST/Family FIRST/Given SECOND/Additional**

**Home mailing address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number & Street/ Route & Box City State Zip Code

**Home Phone:** (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ **Student’s** **Cell phone:** (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

**Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:** \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

MM DD YEAR

**Emergency contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

**Were you enrolled at EMU prior to this admission:** □ yes □ no **Name during prior enrollment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INSURANCE INFORMATION – *Complete page 4 of this form and include a copy of your insurance card – front and back- and upload with your COMPLETED Health Information form***

**\*\*EMU Health Services bills insurance.**

**Family History:**

Have any of your family or blood relatives ever had any of the following illnesses? If yes, please give relationship, i.e. mother, father, uncle, etc.

|  |  |
| --- | --- |
| Asthma | Cancer – type: |
| Depression/anxiety/other | Diabetes |
| Heart disease | High blood pressure |
| Kidney disease | Tuberculosis |
| Any chronic illness not mentioned | Sudden death before age 50 |

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at EMU. It is my responsibility to notify EMU Health Services of health/insurance changes while enrolled. By signing below I authorize release of pertinent medical information and future medical consultations with relevant EMU Departments knowing that all medical information will be kept confidential.

**Signature of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL HEALTH HISTORY – to be **completed by student** **prior to physical**

**Student Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle** any of the following you have had:

Abnormal bleeding/bruising Eating disorder Kidney disorder

Acne Epilepsy, Seizure Menstrual problems (cramping, missed periods)

ADD/ADHD Eye problems, uncorrected Rheumatic Fever

Allergies Head injury Scoliosis

Anemia Headaches, migraine Seizures

Anxiety Hearing impairment Sickle-cell disease/trait

Arthritis Heart disease/arrhythmias Single organs (kidney, eye, etc.)

Asthma, emphysema Hernia Skin problems (recurrent infections, rash, itching)

Broken bones/stress fracture High blood pressure Substance use – alcohol, tobacco, marijuana

Cancer – type: \_\_\_\_\_\_\_\_\_\_\_ HIV/AIDS Undescended testicle

Depression Joint Injury – site:\_\_\_\_\_\_\_\_\_\_\_\_\_ Urinary tract infection

Diabetes

Typical Habits: **Exercise** – YES NO How many times a week? \_\_\_\_ **Sleep** – how many hrs. per night? \_\_\_\_

**Caffeine** – how many cups per day? \_\_\_\_\_

**YES** **NO**

1. Do you have any chronic health problems which require regular treatment or may require treatment? □ □
2. Do you have any disability: physical, emotional, learning, etc.? □ □
3. Have you ever received professional counseling for any psychological problem? □ □
4. Is there any way we can be of assistance to you because of any limitation or health problem you may have? □ □
5. Have you ever passed out during or after exercise? □ □
6. Have you ever been dizzy during or after exercise? □ □
7. Have you ever had chest pain during or after exercise? □ □
8. Do you tire more quickly than your friends during exercise? □ □
9. Have you ever had high blood pressure? □ □
10. Have you ever been told that you have a heart murmur? □ □
11. Have you ever had racing of your heart or skipped heartbeats? □ □
12. Do you use any special equipment daily or with sports (wheelchair, cane, braces) □ □
13. Have you ever had heat stroke or heat exhaustion? □ □
14. Have you ever had a concussion? If yes, how many? \_\_\_\_ □ □

Number of times you lost consciousness \_\_\_\_\_ Dates of concussions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered **YES** to any of the above questions, give significant explanation and dates for each. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations/Surgeries/Injuries – sprains/fractures: (list reasons & dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any illness, injury or chronic health problem other than those already noted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insect/bee stings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications taken regularly (include prescription, over-the-counter, and supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I do not know of any existing physical conditions or additional health reasons that would preclude my participation in collegiate activities and sports. I certify that the answers to the above questions are true and accurate.**

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMU - PHYSICAL & IMMUNIZATION RECORD**

**\*\*Please have a health care provider complete this form and sign it at the bottom.**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name

**EMU ID number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Pronoun(s):** \_\_\_\_\_ **HT:** \_\_\_\_\_\_ **WT:** \_\_\_\_\_\_

Month – Day – Year

**Standing BP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sitting BP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pulse:** \_\_\_\_\_\_\_\_\_\_

**Glasses** - YES NO **Contacts** - YES NO **Eye protection** - YES NO **Vision:** R\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_ **Pupils:** R\_\_\_\_\_\_ L\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mark each item WNL (Within Normal Limits) or A (Abnormal) \*If any Abnormal, explain in comments.** | | | | | |
| **HEENT** |  | **COMMENTS** |  |  | **COMMENTS** |
| Fundoscopic |  |  | Dental |  |  |
| Ears |  |  | Nodes |  |  |
| Mouth |  |  | Lungs/chest |  |  |
| Throat |  |  | Thyroid |  |  |
| Cardiac |  |  |  |  |  |
| **Including precordial auscultation (supine & standing) and femoral artery pulses.** | | | | | |
| Abdomen |  |  | Neuro |  |  |
| Genitalia |  |  | Depression/Anxiety |  |  |
| Hernia |  |  | Other psych.disorders |  |  |
| Skin |  |  |  |  |  |
| **Musculoskeletal** | | | | | |
| Neck |  |  | Hip |  |  |
| Thoracic/Lumbar |  |  | Quad/Hamstring |  |  |
| Shoulder |  |  | Knee |  |  |
| Elbow |  |  | Ankle/Feet |  |  |
| Wrist/Hands |  |  | Gait |  |  |

***TB SCREENING at a U.S. facility is \*\*REQUIRED\*\****

**TB Screening date – Must be within one year of current enrollment: \_\_\_/\_\_\_/\_\_\_ RESULT: Positive / Negative**

**IF TB Screening is POSITIVE, complete a, b, and/or c below.**

a. PPD (Mantoux) Date Given\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date Read\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result \_\_\_\_\_ mm induration (horizontal diameter)

**b. IGRA blood test results (T-Spot, Quantiferon Gold) -- Positive / Negative -- Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

c. Chest x-ray - if positive IGRA blood test or ppd (attach x-ray report)

🞎 INH Prophylaxis: Dates: From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_ OR 🞎 Sign waiver for INH Therapy

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE** | **DATE**  **MM/DD/YY** | **DATE**  **MM/DD/YY** | **DATE**  **MM/DD/YY** | **DATE**  **MM/DD/YY** | **DATE OF**  **TITER/RESULT** |
| **Hepatitis A (2 doses)**  **Hep AB Twinrix (3 doses)** |  |  |  |  |  |
| **Hepatitis B** |  |  |  |  |  |
| **MMR – measles,**  **mumps, rubella**  **(if born after 1956)** |  |  |  |  |  |
| |  | | --- | | **Meningococcal (MenACWY)– one must be given at age 16 or older** | |  | |  |  |  |  |  |
| **Polio-last booster** |  |  |  |  |  |
| **TDAP**  **(within 10 yrs.)** |  |  |  |  |  |
| **Varicella (2 vacc)**  **or yr. of disease** | Vaccine #1: | Vaccine #2: | **Date of disease:** |  |  |

**Meningitis Waiver -** I have read the meningococcal immunization information from the CDC vaccine information sheet at:

http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf . I have chosen not to be vaccinated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Student Printed Name Date

**If you wish to sign a waiver for any other vaccines please go to** [**https://emu.edu/studentlife/health/docs/vaccine-waiver.pdf**](https://emu.edu/studentlife/health/docs/vaccine-waiver.pdf) **-and follow the instructions.**

**Health Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature/Title Phone Number**

**Health Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT NAME Address Fax Number**

**EMU HEALTH INSURANCE INFORMATION**

[*To be completed by student and/or parent/guardian*]

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ EMU ID: \_\_\_\_\_\_\_\_\_\_\_\_\_

* **ATTACH** a legible copy of the front & back of your current insurance card (if covered on multiple plans, please indicate which insurance is **PRIMARY** and which is **SECONDARY** coverage).
* It is recommended for students to keep a copy of their insurance card with them at all times.
* Check with your insurance provider to see what kind of health care coverage you have while attending Eastern Mennonite University (i.e. out of state, out of network, etc.).
* **Provide updated information** to EMU Health Services if you have insurance coverage changes while enrolled at EMU to prevent delays/denials with claims.
* EMU Health Services does not accept **Medicare**.

**Please check all that apply to you currently:**

\_\_\_\_\_ I have **enrolled** for EMU Health insurance coverage.

\_\_\_\_\_ I have **private** health insurance in my/parent’s name, i.e. Aetna, Blue Cross/Blue Shield, Cigna,

Kaiser, Optima, United, etc.

PARENTS/Guardians: PLEASE NOTIFY YOUR HEALTH INSURANCE COMPANY that your son/daughter will be a full time student at Eastern Mennonite University in Harrisonburg, VA- BEFORE arriving on campus. This will confirm whether your son/daughter will be covered while at EMU.

**Name** **of Insurance Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ I have **Medicaid** coverage. If yes: \_\_\_\_\_\_ VA Medicaid \_\_\_\_\_\_\_Out-of-state Medicaid

NOTE: **Virginia Medicaid is the only Medicaid accepted by EMU Health Services.**

\_\_\_\_\_ I do not have health insurance and expect to pay the “Self-pay” charge at the time of service.

**Patient Insurance Authorization:**

I hereby authorize EMU to furnish information to insurance carriers concerning my illness, condition, and treatment, and I hereby irrevocably assign to EMU Health Services all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges that may be charged to my student health account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policyholder/Subscriber Policyholder/Subscriber’s Birthdate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian (IF STUDENT IS UNDER 18) Date

**Physician Clearance to Participate in NCAA Intercollegiate Athletics**

**MEDICAL DOCUMENT FOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sport:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(**Athlete’s full name)

**BANNED MEDICATION STATEMENT:**

The NCAA list of [banned drug classes](https://www.ncaa.org/sports/2015/6/10/ncaa-banned-substances.aspx) (NCAA Division I Bylaw 18.4.1.4.6 and NCAA Division II and III Bylaw 31.2.3.1) is composed of substances that are generally purported to be performance enhancing and/or potentially harmful to the health and safety of the student-athlete.

The NCAA recognizes that some banned substances are used for legitimate medical purposes. Accordingly, the NCAA allows exception to be made for those student-athletes with a documented medical history demonstrating the need for treatment with certain banned medications. Medical exceptions may be granted for substances in the following banned drug classes: anabolic agents\*, stimulants, beta blockers, diuretics and masking agents, hormone and metabolic modulators\*, beta-2 agonists, peptide hormones\*, growth factors or related substances and mimetics\*, and narcotics (see subpart 2 below). Per NCAA Division I Bylaw 18.4.1.4.8 and Division II and III Bylaw 31.2.3.2, a medical exception is not permitted for a substance in the class of cannabinoids.

*\*Note: The use of an anabolic agent, hormone and metabolic modulator, peptide hormone, growth factors, related substances and mimetics must be approved by the NCAA before the student-athlete is allowed to participate in competition while taking these medications.*

\*\*A [medical exemption form](https://ncaaorg.s3.amazonaws.com/ssi/substance/SSI_MedicalExceptionReportingForm.pdf) must be completed for those individuals taking medications to treat ADD/ADHD.

**SICKLE CELL STATEMENT:**

The NCAA has asked member institutions to educate all athletes on sickle cell trait. Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin (red blood cell) and one for normal hemoglobin. Sickle cell trait is a lifelong condition that will not change over time. The danger of this condition occurs when an athlete with sickle cell trait exercises intensely. Some athletes have experienced significant physical distress, collapse and some have even died. To be in compliance with NCAA requirements you must identify your sickle cell trait status. The test for sickle cell trait may have been conducted at your birth. More information on sickle cell trait can be obtained from the NCAA at <https://www.ncaa.org/sports/2016/7/27/sickle-cell-trait.aspx>.  Please be aware that having this condition will not exclude your participation but will require that exercise precautions be put in place. Failure to comply with this requirement will delay your clearance to participate.

**\*\* YOU MUST PROVIDE A COPY OF THE LAB RESULTS TO EMU ATHLETIC TRAINING\*\***

**PHYSICIAN CLEARANCE:**

I have examined the above named student and completed the pre-participation evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined below. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

 \_\_\_ A.  Cleared for all sports without restriction

 \_\_\_ B.  Cleared without restriction with recommendation after completing evaluation/rehabilitation for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ C.  Not cleared for: \_\_\_\_\_\_Pending further evaluation \_\_\_\_\_ For Any Sports  \_\_\_\_\_For Certain Sports

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Examiner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MD, DO, PA, NP)   Date: \_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Examiner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

                Street/Route                                                       City                                              State            Zip Code

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_