Nova Southeastern University Health Professions Division

Certificate of Physical Examination

Based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office this date_____, it is my impression that

Name of student_____

Social Security Number_____

College Program_____

Date of Birth_____

has received the required immunizations and that he/she meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

I certify that the information herein is complete and accurate to be best of my knowledge.

Healthcare Provider Printed Name_____

Date_____

Healthcare Provider Signature_____

MANDATORY Office or Healthcare Provider Stamp:

Office Phone Number_____

Office Address_____