Certificate of Medical Examination

To be completed by Physician and returned to:

Admissions Office
Faith School of Theology
29 Main Road
Charleston, ME 04422

Name: _____

Address: _____

_____
City *State* *Zip*

I certify that I have examined the above named applicant on: _____
Date

and found him/her to be of sound mental and physical health, free from comminicable disease or physical defect which might interfere with his/her success at Faith School of Theology.

Please list any existing ailments and Rx for existing ailments:

_____

_____

_____

Please supply Immunization record (if available).

Physician's Signature:_____ Date: _____

Physician's Address: _____

_____
City *State* *Zip*

Physician's Telephone Number (____)_____