**Physical Exam Health Clearance Form**

**California State University, Dominguez Hills**

**Student Name:** _____

**Date of Physical Exam:** _____

**Health Care Provider (MD,DO,NP,PA) Name:** _____

**Office Address:** _____

I certify that the student as named above has received a physical examination. She/he is free of communicable diseases and able to perform daily activities as a nurse.

Should you have any questions, please contact me at (  ) ____ - _____

_____

**Health Care Provider's Signature**