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