Office of Enrollment Planning
17950 Preston Road, Suite 460, Dallas, Texas, USA 75252
Toll Free 1-888-440-4474
Tel. 972-484-9700
Fax: 972-484-9970

MEDICAL FITNESS CERTIFICATE

I, DR. _____, AM EXAMINING THE CANDIDATE LISTED BELOW FOR ADMISSION INTO A MEDICAL SCHOOL. I DO HEREBY CERTIFY THAT THE ABOVE STUDENT IS IN GOOD HEALTH AND IS NOT SUFFERING FROM ANY COMMUNICABLE DISEASES. I ALSO CERTIFY THAT I DO NOT SEE ANY PHYSICAL OR MENTAL IMPEDIMENT IN THIS CANDIDATE, WHICH WOULD PRECLUDE SUCCESSFUL COMPLETION OF HIS/HER MEDICAL EDUCATION.

STUDENT INFORMATION

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

DOB: _____ SS# _____
MM/DD/YYYY

Primary Phone #: ( ) _____ *Please indicate:* ☐ Home ☐ Cell ☐ Work

Cell Phone #: ( ) _____

PHYSICAL EXAMINATION

General Health: ☐ Good ☐ Fair ☐ Poor

Medically Fit for Rotations: ☐ Yes ☐ No

Date of Examination: _____ Physician's Name: _____

Address: _____

Telephone Number: ( ) _____ Fax Number: ( ) _____

Physicians Signature: _____

Please attach a copy of Physical Examination Completed

IMMUNIZATION HISTORY (Within 10 years date, otherwise provide titers. All clinical students must provide titers.)

MEASLES *(2 doses at least one month apart, after 12 months age)*

Date #1: _____ Date #2: _____

or proof of immunity (measles titer) Date & Results: _____

MUMPS *(1 dose)* Date: _____

or proof of immunity (mumps titer) Date & Results: _____

RUBELLA *(German measles, 1 dose)* Date: _____

or proof of immunity (rubella titer) Date & Results: _____

DTAP *(2 dose - after 12 months age)* Date: _____

INFLUENZA *(updated annually)* Date: _____

VARICELLA

History of having had chickenpox (*Please check one):* ☐ Yes ☐ No

or proof of immunity (varicella titer) Date & Results: _____

PPD** ***(Mantoux)

Date & Results: _____

*****Must be within one (1) year and updated annually. Chest x-ray is required if tested positive. *****

Positive PPD Test Dates: _____

BCG Vaccine & Chest X-ray *(Non-US)* _____

HIV

Test Date & Results: _____

(must be current within 60 days of matriculation)

REQUIRED PRIOR TO CLINICAL PROGRAM

For those individuals having direct patient contact or any possibility of contact with blood of body fluids, Hepatitis series or declination is required

Hepatitis B Vaccine

Dates #1: _____ Dates #2: _____ Dates #3: _____

REQUIRED PRIOR TO CLINICAL PROGRAM *continuation*

HBSAB following series--Date & Results: _____

Declination signed and on file Date: _____

_____ _____

Physician Initials **Date**