HEALTHCARE PROVIDER CLEARANCE

Student Name: _____

Date of Physical Examination: _____

I have examined the above-named student and, based upon my evaluation, the student is:

☐ **Medically cleared to participate** in the educational program, including classroom, laboratory, simulation, and clinical activities.

☐ **Medically cleared to participate with reasonable accommodation and/or restrictions.**

If restrictions or accommodations are indicated, please provide appropriate documentation describing the functional limitation or restriction without including unnecessary diagnostic information.

☐ **Not medically cleared at this time.**

Healthcare Provider Name: _____

Credentials: _____

Provider Signature: _____

Date: _____

Practice/Facility: _____

Phone: _____

Office Stamp, if applicable: _____