ALLIED HEALTH
PHYSICAL EXAMINATION FORM

1. **Name:** ____

2. **Date of Birth:** ____

3. **Address:** ____

4. **Phone: (______) - _______ - __________**

5. **TB Test Administered on : _________Results: ________ Read by: _____________**

Second Step for Allied Health students - administered 7 days after first one is read.

Second step administered on: __________ Results: __________ Read by:_____________

6. **Hepatitis B Vaccine #1_________ #2 __________ #3 ___________**
(Date) (Date) (Date)

7. **PHYSICIAN AFFIDAVIT (Must be completed by examining physician)**

I, a licensed and registered Physician, under the laws of the Commonwealth of Pennsylvania, County of _______________have examined _________________and find him/her to be free of all infectious diseases with the ability to lift, push, pull, and transfer a minimum of 50 pounds.

____
Physician's Signature

____
Physician's Printed Name

____
Physician's Registration Number

____
Physician's Address

____
Date

Office Stamp

STU-024c
(Rev. 6/03/07)