ATLANTIC CAPE COMMUNITY COLLEGE | HEALTH PROFESSIONS INSTITUTE

Physician Report Form

Please bring this form with you to your primary care provider to insure that you meet all requirements. ***This form must be completed by your physician no sooner than 2 months prior to first date of class. Clinical sites may require this report to be performed again prior to your internship.**

Please Print
Student Name: _____Phone#: _____

Address: _____

Check Program: ____ EMT _____Paramedic ____Phlebotomy Technician

____Certified Clinical Medical Assistant_____ Other

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Heart: Is there any:
Enlargement Yes ____ No ____ Dyspnea Yes ____ No ____
Murmur Yes ____ No ____ Edema Yes ____ No ____

Is there on examination any abnormality of the following?

1. Eyes, ears, nose, mouth, pharynx? Yes ____ No ____
2. Skin; lymph nodes; varicose veins or peripheral arteries? Yes ____ No ____
3. Nervous system, including reflexes, gait? Yes ____ No ____
4. Respiratory system? Yes ____ No ____
5. Abdomen, including scars? Yes ____ No ____
6. Genitourinary system, including prostate? Yes ____ No ____
7. Endocrine system? Yes ____ No ____
8. Musculoskeletal system? Yes ____ No ____
9. Are there any hernias? Yes ____ No ____
10. Are there any hemorrhoids? Yes ____ No ____
11. Are you aware of additional medical history or physical limitations that would prevent this patient from performing the duties of a **program above?** Yes ____ No ____

Please describe below any "yes" response. Designate the # from above.

Physician's Signature: _____ Date: _____

Print Physician's Name and Address: _____

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