NOVA SOUTHEASTERN UNIVERSITY HEALTH PROFESSIONS DIVISION
CERTIFICATE OF PHYSICAL EXAMINATION

Based on review of the patient's medical history, immunization records, and physical examination performed and on file in my office this date ________________________________, it is my impression that

Name of student ________________________________ Student ID ______________________________

College Program: ______College of Pharmacy__________ Date of Birth ____________________________

has no clinical evidence of infectious or contagious disease, that he/she has received the required immunizations and that he/she meets the physical requirements for attendance at Nova Southeastern University Health Professions Division.

I certify that the information herein is complete and accurate to the best of my knowledge.

Healthcare Provider Printed Name ______________________________ Date ____________________________

Healthcare Provider Signature ________________________________

MANDATORY
Office or Healthcare Provider Stamp:

Office Phone Number ______________________________________

Office Address ____

NOTE: Students are required to keep two (2) copies of this form for themselves. Original form will not be available to you after submission.

Return completed form to:

NSU, College of Pharmacy ✍ Office of Student Affairs ✍ 3200 South University Drive ✍ Fort Lauderdale, FL 33328