Medical Assisting Program Physical Form

Applicant must be examined by a Licensed Health Care Provider
(Physician, Nurse Practitioner, or Physician Assistant)

Patient Name: ____

Date of Exam: ____

Temperature_________Pulse_________ Respirations_______ BP__________
Height_________ Weight_________ Vision_________Hearing Exam_________

Examination (To be completed by Physician)

Body System	Normal	Abnormal	Comments
EENT			
Neck			
Chest			
Heart			
Abdomen			
Extremities			
Back			

Is the applicant taking any medications that could result in a positive drug screen?
Yes_______ No_______

In view of the rigorous requirements of the Medical Assisting program and the result of your physical examination, patient's current medications, and patient's mental and emotional stability, do you believe that this applicant is physically/emotionally able to safely complete a Medical Assisting program?
_____Yes _____No If No, please explain:

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Physician Printed Name: ____

Signature: ____

Credentials: _______________________________

Date: _____________________________________