

Name: _____
(Please Print)

Student Identification #: _____
(7 Digit #)

CHEST X-RAY (Required if tuberculin skin test is Positive)

XRAY DATE _____ / _____ / _____
(Month / Day / Year)

RESULTS?

Normal / Abnormal (circle one)

Comments (Required if tuberculin skin test is Positive) : _____

PART III: EXAM EVALUATION AND VERIFICATION
(HEALTH CARE PROVIDER TO COMPLETE)

I have obtained a health history, performed a physical examination and reviewed the student's immunization status and required laboratory tests. In my opinion this student is able to fully participate in the School of Nursing program:

Yes / No (circle one)

If this student is NOT fully able to participate, please comment on activity limitations below:

NOTICE: The YEAR on the Provider date below must correspond with the upcoming calendar year that is going to be covered by the data on this form.

PROVIDER INFORMATION

Name _____
(Please Print)

CRNP / MD / DO / PA (circle one)

Signature _____

Date _____ / _____ / _____
(Month / Day / Year)

Phone Number: (____) _____

NOTE: ALL SECTIONS ON THIS FORM MUST BE COMPLETED BEFORE ITS SUBMITTAL

FORM SUBMITTAL (Upon Completion)

This form should be returned **BY THE STUDENT** to:

University of Pittsburgh
Student Health Service
Medical Arts Building
Suite 500
3708 Fifth Avenue
Pittsburgh, PA 15213