



College of Pharmacy
Office for Student Affairs

HPNP Complex
PO Box 100495
Gainesville, FL 32610-0495
352-273-6217
352-273-6219 Fax

PHYSICAL EXAMINATION

Name: _____ UF ID #: _____
LAST, FIRST

Campus site (circle one): G J O S
Dear Health Care Provider:

Please sign below for **ONE** of the statements to indicate whether this individual has had a **physical exam** and indicate if this individual **may or may not** enter health care settings based on your assessment.

.....

After completion of a physical examination this individual is in satisfactory health to participate in required activities as part of practicum and clerkship course responsibilities in clinical settings inclusive of community pharmacies, hospitals, and other health care institutional settings.

Printed Name of Health Care Provider Date

Signature of Health Care Provider

After completion of a physical examination this individual is NOT in satisfactory health to participate in required activities as part of practicum and clerkship course responsibilities in clinical settings inclusive of community pharmacies, hospitals, and other health care institutional settings.

Printed Name of Health Care Provider Date

Signature of Health Care Provider