UNIVERSITY OF MARYLAND EASTERN SHORE

SCHOOL *of* PHARMACY *and* HEALTH PROFESSIONS
DEPARTMENT *of* PHYSICIAN ASSISTANT

Student Health Clearance Form

MUST BE COMPLETED BY STUDENT'S HEALTHCARE PROVIDER

Student Name:_____ Date of Birth:_____

After a review of all health information, I certify this student is found to be in good physical and mental health and appears able to perform physician assistant student responsibilities.

(check appropriate line): with accommodations _____ without accommodations _____

Practitioner's name (print):_____

Practitioner's address (print):_____

Practitioner's phone number (print):_____

_____ Date_____

Signature and/or stamp of health care provider

Mail or Fax completed form to: University of Maryland Eastern Shore
PA Program Requirements
Hazel Hall, Suite 1062
11868 Academic Oval
Princess Anne, MD 21853
Fax: (410) 651-7586