

**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 _____ Social Security Number _____

College Program _____ Date of Birth _____

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 be best of my knowledge.

Healthcare Provider Printed Name _____

Date _____

Healthcare Provider Signature _____

MANDATORY

Office or Healthcare Provider Stamp:

Office Phone Number _____

Office Address _____

Return completed form prior to start of program to:
Specific College and/or Program in which you will be enrolling
NSU Health Professions Division
3200 S. University Drive Ft. Lauderdale, FL 33328
Phone 954-262-1101 Fax 954-262-2282