HEALTH CERTIFICATION

**The Applicant must retain a copy to show Practicum Site Director.**

MILWAUKEE AREA TECHNICAL COLLEGE

700 WEST STATE STREET

MILWAUKEE, WISCONSIN 53233

FIRST NAME: Click here to enter text.

BIRTH DATE Click here to enter text.

ADDRESS: Click here to enter text.

CITY/STATE: Click here to enter text.

ZIP CODE: Click here to enter text.

PROGRAM NAME: Click here to enter text.

LAST NAME Click here to enter text.  
SEMESTER START: Click here to enter text.

TELEPHONE #: Click here to enter text.

E-MAIL ADDRESS: Click here to enter text.

STUDENT ID: Click here to enter text.

ONLY PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, TO COMPLETE THE FOLLOWING:

I have examined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and certify that she/he is in good physical and mental health.

Student’s Name

On letterhead stationery, please list any physical limitations or other disabilities which would limit this individual’s capacity to perform the essential functions of this profession.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name Office Telephone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider **SIGNATURE** & Medical Title Date

A full exam is on file at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MANTOUX TUBERCULIN SKIN TEST: This must be administered within one year of date of program entry.

PROCEDURE:

Step 1:

1. A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered to all individuals who have never had a two-step skin test or to those individuals who have not had a PPD within the last two years.
2. A health care professional must read the results within 48-72 hours.

If positive, must follow-up with a chest x-ray.

**REPORTING RESULTS**

1. Step 1 Results

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Administered Date Read Results Authorized Signature & Medical Title

1. CHEST X-RAY (indicated only when Tuberculin Skin Test is Positive)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Administered Date Read Results Authorized Signature & Medical Title

**PLEASE NOTE: You MUST make a copy of your completed health form and retain it. You may need to provide it to a practicum placement site.**

**IMPORTANT**

**I give permission to release information on this health form to the professional college and practicum placement site staff if it is deemed necessary for the benefit and/or safety of myself and others.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Student**

**INTRUCTIONS TO STUDENTS**

* **Did your doctor or authorized medical person sign every authorized signature, dates and results of tests?**
* **Is your physical exam completed and all necessary information on the form completed? i.e. (signature, print name, address, telephone #, test results, etc.)**
* **Do you have a copy?**