Clinical Externship

Physician Statement & Health Status Form

PLEASE SUBMIT THIS FORM PRIOR TO RETURNING CLINICAL EXTERNSHIP DOCUMENTS REQUESTED.

_____

First Name Middle Name Last Name

Medical Release Authorization (to be completed by applicant):

I, _____ do hereby authorize _____ to release any
(Applicant Name) (Physician Name)
information acquired during my medical examination to the Center for Professional Education at UT-Chattanooga. I also authorize CPE at UTC to release any information on this statement, to potential volunteer/clinical externship facilities as requested.

_____

Applicant Signature Date

STATEMENT OF PHYSICAL HEALTH
(To be completed by the physician)

The above named individual has been examined by me and is found to be in good physical and mental health, free from communicable diseases, and able to function and perform all job duties as a healthcare student clinical extern, without any limitations, in his/her profession at full capacity.

Physician Signature: _____ Date: _____

Physician Name (Please Print): _____

Physician Street Address (Please Print):_____

Physician City, State, and Zip code (Please Print)_____

Physician Telephone Number:_____

Please fax or email completed statement to**: William Watson, Program Coordinator / P: 423-425-4344 F: 423-425-4170 /** **william-a-watson@utc.edu**