UCF College of Medicine

UNIVERSITY OF CENTRAL FLORIDA

PHYSICAL EXAMINATION VERIFICATION

To Be Completed by Student *(Please Print)*

MUST BE COMPLETED* 12 MONTHS *PRIOR TO ENROLLMENT.

_____ _____ _____

LAST NAME **FIRST NAME** **MIDDLE NAME**

_____

DATE OF BIRTH (MM/DD/YEAR)

Do you have any health problems or concerns of which UCF Student Health Services should be aware?

☐ **Yes** ☐ **No**

If you wish to receive care for the above problems or concerns at UCF Student Health services, it is your responsibility to make a follow-up appointment and to provide copies of pertinent medical records as necessary.

_____ _____

Student Signature **Date**

To Be Completed by Physician

A thorough history and physical examination were completed on the above named individual, with the following results:

☐ All findings were within normal limits

☐ Follow-up care is required; patient was advised

_____

_____

_____

_____ _____ _____

Physician Signature **Print Name** **Date**

_____ _____

Facility Name (*Please Print)* **Office Phone Number**

_____ _____ _____

Address **City & State** **Zip Code**

UPLOAD TO CASTLEBRANCH DIRECTLY. *DO NOT SEND* TO UCF COLLEGE OF MEDICINE.