GARDNER-WEBB UNIVERSITY
PHYSICIAN ASSISTANT STUDIES

RETURN TO:
Gardner-Webb University
Physician Assistant Studies
Attn: Allison Qualls
PO Box 7252
Boiling Springs, NC 28017

ANNUAL HEALTH ASSESSMENT

To be completed by student:

Name _____ Date of Birth _____
(First, Middle, Last) *(Month, Day, Year)*

I understand the facility to which I am assigned may require more health data than listed below. I hereby authorize Gardner-Webb University to release the information below to any affiliated medical facility which may require it in connection with program assignments or clerkships.

Student's Signature (Required) _____ Date _____

I find him/her to be in good health. He/she is free of any health impairment which may pose a potential risk to personnel, or which may interfere with the performance of clinical responsibilities. Habituation to alcohol or other drugs which may alter the individual's behavior has been considered in this evaluation. **To the best of my knowledge this student is able to fully participate in clinical clerkship education at medical facilities.**

Signature of Examining Physician Assistant, Physician, or Certified Nurse Practitioner _____

Print or Type Name _____

Telephone Number _____

Date of Complete Physical Examination _____

Address Stamp of Provider/Health Facility (Required)