

OFFICE OF EXPERIENTIAL EDUCATION

Dear Health Care Provider,

In order to comply with requirements of some of our pharmacy experiential sites, this student needs a physical examination to participate in their clinical rotations. We receive no definitive guidelines from our experiential partners regarding the scope and depth of this examination, only that it be completed within a year of assignment to a particular site.

The attestation below is sufficient to document this requirement. Alternately we can accept your own form* or letter that must include:

- A statement noting that the student has undergone a physical examination and does not present apparent clinical contraindications to participate in clinical practicum experiences / rotations,
- Student name and date of birth,
- Date of physical exam,
- Provider address and phone number,
- Health Care Provider signature.

*We cannot accept any forms that include specific medical information (e.g. history, diagnoses, recommendations, etc.)

A copy of the physical exam should be on record and made available to the school at the request of the student if needed.

More information about our experiential curriculum is available [on our website](#).

If you have any questions, please contact Nicole Gattas, director of experiential education, at nicole.gattas@uhsp.edu or 314.446-8555.

OFFICE OF EXPERIENTIAL EDUCATION

Physical Examination Attestation Form

Student

Last
First
Middle

Student DOB

Month
Day
Year

Please check the boxes below to confirm attestation and add date of physical examination where noted.

Attestation	<input type="checkbox"/> I examined the above-named student and completed a pre-participation physical examination on this date (within 12 months): <div style="text-align: center; margin-top: 5px;"> ____ / ____ / ____ </div> <input type="checkbox"/> The student does not present apparent clinical contraindications to participate in clinical practicum experiences / rotations. A copy of the physical exam is on record in my office and can be made available to the school at the request of the student.
--------------------	---

Health Care
Provider

Last
First
Credentials

Clinic Address

Street
City
State
Zip Code

Telephone

Provider Signature _____ Date _____