SCHOOL OF NURSING
UNIVERSITY OF MICHIGAN

Office of Practice and Professional Graduate Program
PHONE: 734-763-7304
EMAIL: UMSN-GraduateClinicalPlacement@med.umich.edu

PHYSICAL EXAMINATION FORM

TO BE FILLED OUT BY THE STUDENT

First Name	Last Name	UM ID	
Uniqname	Phone Number	DOB	Sex
Address	City	State	Zip

TO BE FILLED OUT BY THE HEALTHCARE PROVIDER

☐ I have given the student a complete physical examination and reviewed their health history. I feel that the student is physically and mentally capable of participating without hazard in clinical practice settings for the University of Michigan School of Nursing.

☐ I have given the student a complete physical examination and review their health history. I feel that the student is **NOT** physically and mentally capable of participating without hazard in clinical practice settings for the University of Michigan School of Nursing.

Healthcare Provider's Name and Title (Please Print)

Healthcare Center/Facility

Healthcare Provider's Signature

Address, City, State, Zip

Date

Phone Number

Please provide comments or concerns with the students capability of participating in clinical please comment below: