



**ARMSTRONG ATLANTIC STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS**

ANNUAL PHYSICAL EXAM

Please Print

Student Name:	Social Security(Last 4 digits)
Address:	
<u>Date of Physical</u>	<u>Name of Examiner (Please Print)</u>
I have examined _____ and find that he/she has:	
1. No evident of health problems which could interfere with his/her performance of required clinical activities.	
2. The following health problem(s)/restriction(s) which may/may not interfere with his/her performance of required clinical activities. (Please explain and attach additional pages if necessary.)	
3. Significant health problem(s) which would interfere with his/her performance of required clinical activities. (Please explain and attach additional pages if necessary.)	
Signature of Health Care Provider	Street Address/City/State/Zip Code

RETURN TO:

**Armstrong Atlantic State University
Medical Technology Department
11935 Abercorn Street
Savannah, GA 31419-1997
Fax #: (912) 921-5585**