



## Office of Admissions

5999 Summerside Drive, Suite 220, Dallas, Texas, USA 75252  
Toll Free 1-888-440-4474 or 972-484-9700 Fax 972-484-9970

# MEDICAL FITNESS CERTIFICATE

I, DR. \_\_\_\_\_, AM EXAMINING THE CANDIDATE LISTED BELOW FOR  
ADMISSION INTO A MEDICAL SCHOOL. I DO HEREBY CERTIFY THAT THE ABOVE STUDENT IS  
IN GOOD HEALTH AND IS NOT SUFFERING FROM ANY COMMUNICABLE DISEASES. I ALSO  
CERTIFY THAT I DO NOT SEE ANY PHYSICAL OR MENTAL IMPEDIMENT IN THIS CANDIDATE,  
WHICH WOULD PRECLUDE SUCCESSFUL COMPLETION OF HIS/HER MEDICAL EDUCATION.

### REQUIRED FOR BASIC SCIENCE STUDENTS

General Health:  Good  Fair  Poor

Date of Examination: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Physicians Signature: \_\_\_\_\_

### STUDENT INFORMATION

Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street City State Zip Code

DOB: \_\_\_\_\_ SS# \_\_\_\_\_  
MM/DD/YYYY

Primary Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Please indicate:  Home  Cell  Work

Secondary Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Please indicate:  Home  Cell  Work

**IMMUNIZATION HISTORY (DT/Td within 10 years date)**

**MEASLES** (2 doses at least one month apart, after 12 months age)

Date #1: \_\_\_\_\_ Date #2: \_\_\_\_\_

**MUMPS** (1 dose) Date: \_\_\_\_\_

or proof of immunity (mumps titre) Date & Results \_\_\_\_\_

**RUBELLA** (German Measles, 1 dose) Date: \_\_\_\_\_

or proof of immunity (rubella titre) Date & Results \_\_\_\_\_

**CHICKENPOX**

History of having had chickenpox (Please check one):  Yes  No

\***PPD** (Mantoux)

Date & Results: \_\_\_\_\_  
(must be within one year and updated annually) Chest x-ray is required if tested positive.

**Positive PPD** Test Dates: \_\_\_\_\_

**BCG Vaccine & Chest X-ray** (Non-US) \_\_\_\_\_

**HIV**

Test Date & Results: \_\_\_\_\_  
(must be current within 60 days of matriculation)

**REQUIRED PRIOR TO CLINICAL PROGRAM**

*For those individuals having direct patient contact or any possibility of contact with blood of body fluids, Hepatitis series or declination is required*

**Hepatitis B Vaccine**

Dates #1: \_\_\_\_\_ Dates #2: \_\_\_\_\_ Dates #3: \_\_\_\_\_

**REQUIRED PRIOR TO CLINICAL PROGRAM continuation**

*HBSAB following series--* Date & Results: \_\_\_\_\_

Declination signed and on file Date: \_\_\_\_\_

\_\_\_\_\_  
**Physician Initials**

\_\_\_\_\_  
**Date**