**Email the completed form in PDF format to pas@nyit.edu and program chairperson**

# PA STUDIES
# HEALTH CLEARANCE FORM
# DIDACTIC PHASE

NEW YORK INSTITUTE OF TECHNOLOGY
School of Health Professions

***To be completed by student:***

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

Student's Signature (Required): _____ Date: _____

***To be completed by health care provider:***

I have performed an evaluation of the above named individual.

I find him/her to be in good health. He/she is free of any health issues which may pose a potential risk to fellow students, personnel, patients or family, or him/her self. 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 attend on campus classes.**

***Address Stamp of Provider/Health Facility (Required)***

_____ _____
*Signature of Evaluating PA, Physician or Certified Nurse Practitioner* *Health Evaluation Date of Completion*

_____ _____
*Print or Type Name* *Telephone Number*

SR (X/Form) 08192020