Stark State College
Health and Public Services Division

Physical Exam Verification

Student Name_____ Student ID _____

Program_____

This section is to be completed by your physician/healthcare provider (DO, MD, NP, PA).

Office Name _____

Office Phone _____

HealthCare Provider Printed Name _____

Contact Person _____

This is to certify that the above student had a physical exam on _____ (date) and is in apparent good health, has no condition that would endanger the health and wellbeing of students, College staff, or patients, and is physically/mentally able to participate in the STNA program at Stark State College.

_____
Healthcare Provider Printed Name

_____
Healthcare Provider Signature Date