WORSHAM COLLEGE OF MORTUARY SCIENCE
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CERTIFICATE OF HEALTH

APPLICANT: Complete the applicant section of this form. The physician who examines you MUST hold an active license in the jurisdiction in which he practices. Direct the physician to complete the Examining Physician Section of this form and return the completed form to you.

1. NAME FIRST MIDDLE LAST	2. DATE OF BIRTH ____ Month / ____ Day / ____ Year	3. SOCIAL SECURITY NUMBER
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. EMAIL ADDRESS	

EXAMINING PHYSICIAN: Complete the remainder of this form. Return the completed form to the applicant. Physical examination must have occurred within the preceding 12 months.

A. PHYSICIAN'S NAME FIRST MIDDLE LAST	B. PHYSICIAN'S LICENSE NUMBER
C. STREET ADDRESS	D. STATE OR TERRITORY OF LICENSURE
E. CITY, STATE, ZIP CODE	F. DATE OF APPLICANT'S PHYSICAL EXAMINATION OR IMMUNIZATION

THIS IS TO CERTIFY THAT _____
(Applicant's Name)

Has received the following immunizations:

D.P.T. SERIES. . . . . DATE _____

BOOSTER . . . . . DATE _____

T.B. PATCH TEST . . . . . DATE _____

Positive _____ Negative _____

Hepatitis Vaccination -- 3 Shot Series _____

And has been thoroughly examined by me, and I find him/her to be in normal health, with the following exceptions:

_____

_____

Dated this _____ day of _____, 20 ____.

_____ M.D.

NO STUDENT WILL BE PERMITTED IN THE EMBALMING OR ANATOMY LABORATORY WITHOUT THIS COMPLETED FORM.