

MEDICAL CLEARANCE FORM

Program you are applying to:

(Please type below)

Last Name First Name Middle Initial

Fresno State Student ID OR Social Security

Primary Email Address Gender

CERTIFICATION BY DIRECTOR OF STUDENT HEALTH SERVICES OR PRIVATE PHYSICIAN

This is to certify that the applicant is negative for active Tuberculosis within the last year and the results were negative.

(EC44336 – This student is “free from any contagious and communicable disease or defect unfitting the applicant to instruct or associate with children.”)

Date Health Center Director or Private Physician's Signature

Office Address (If private Physician)

DO NOT SUBMIT A COPY OF YOUR TEST RESULTS, HAVE THE PHYSICIAN SIGN THIS FORM ONLY.