Return to:

ECU Office of Clinical Experiences, Speight 110

Internship I interns **MUST** turn in this form by the due date to continue their internship. Valid for one year from date of physical.

Make sure you have a copy of this form. The Office of Clinical Experiences will NOT provide copies at any time.

Internship Physical Form

The Health Examination form is required of all persons before their initial visit to their Internship location.

Name:____ **ECU ID**: _B___________________________

Address: ____

____

Program Area: ____

I. Communicable Disease

By my signature I certify that the above **named person does not have any communicable disease, including tuberculosis,** that poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted below. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

____

____

II. Other Health Areas

Areas	Limitations Yes	No	Nature of Limitations (continue on back as needed)
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			

Appropriate Immunizations	Yes	No	Any Immunization Recommendations
TD (tetanus), MMR, Hepatitis B, etc.			
Tuberculin (TB) test (Must be within 12 months of Internship) Note Date Given, Read, and Result.	**Date Given**	**Date Read**	**Result**

Physicians Office: ____________________________________ Telephone Number (____)__________________

Physicians Name: ____________________________________ Fax Number (____)________________________
(Please Print)

Physicians Signature____ Date: ___________________