

WORSHAM COLLEGE OF MORTUARY SCIENCE
 495 Northgate Parkway • Wheeling, Illinois 60090 • 847-808-8444

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 LAST FIRST MIDDLE	2. DATE OF BIRTH ____/____/____ Month Day Year	3. SOCIAL SECURITY # ____ - ____ - ____
4. ADDRESS STREET	CITY, STATE, ZIP CODE	
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 NAME FIRST MIDDLE LAST	B. PHYSICIAN LICENSE NUMBER	
C. STREET ADDRESS	D. STATE OR TERRITORY OF LICENSE	
E. CITY, STATE, ZIP CODE	F. DATE OF APPLICANT'S PHYSICAL EXAMINATION OR IMMUNIZATION	

THIS IS TO CERIFY 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 _____, 200_____.

_____ M.D.

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