ROXBOROUGH MEMORIAL HOSPITAL
SCHOOL OF NURSING
MEDICAL CLEARANCE FORM FOR PHYSICAL INJURY/CONDITION
All fields MUST be completed by a Physician or Physician Extender

Student Name:			
Date of Birth:	/ /	Gender:	BP: _____ / _____ P:_____
Age:		Ht: _____ Wt: _____ BMI: _____	
Diagnosis:			
Date of Visit:		Date Cleared to Return:	

REQUIREMENT	**ABLE TO PERFORM**	**UNABLE TO PERFORM**
Sitting (intermittently and for extended periods)		
Standing (intermittently and for extended periods)		
Walking (intermittently and for extended periods)		
Wrist Deviation (for extended periods)		
Hand/ Wrist Repetitions (for extended periods)		
Reaching (intermittently and for extended periods)		
Lifting and carrying (up to 50 lbs.)		
Lifting and carrying with assistance (0-100 lbs. or above)		
Twisting/ Bending (intermittently and for extended periods)		
Squatting/ Kneeling/ Crawling (intermittently and for extended periods)		
Grasping (for extended periods)		
Pulling/ Pushing (up to 50 lbs.)		
Pulling/ Pushing with assistance (0-100 lbs. or above)		

PLEASE NOTE: It is an expectation of the Roxborough Memorial Hospital School of Nursing that Student Nurses are able to perform the duties listed above without restrictions. The School will attempt to address all "Reasonable Accommodations" as stipulated by the American Disability Act (ADA).

PROVIDER'S NAME	SPECIALTY	STATE LICENSE #	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE	FAX		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. By signing, I acknowledge that the above named individual is medically cleared to perform the duties of a student nurse in the classroom and clinical setting with no restrictions.

PROVIDER'S SIGNATURE (INCLUDE CREDENTIALS)	DATE

Health Care Provider Seal/Stamp Here