

# Program Participation Clearance

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date of Physical Examination: \_\_\_\_\_

\_\_\_\_\_ I certify that the above named patient is able to participate in the full extent of the Southern California University of Health Sciences (SCU) Master of Science: Physician Assistant (MSPA) Program and meets the Technical Standards set forth by the program.

\_\_\_\_\_ I certify that the above named patient is able to participate in the Southern California University of Health Sciences (SCU) Master of Science: Physician Assistant (MSPA) Program but will require reasonable accommodations to meet the Technical Standards set forth by the program.\*

\_\_\_\_\_ I certify the above named patient is not cleared to participate in the Southern California University of Health Sciences (SCU) Master of Science: Physician Assistant (MSPA) Program.

Healthcare Provider Name: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Healthcare Provider

\_\_\_\_\_  
Date