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 Master of Science: Physician Assistant 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 Master of Science: Physician Assistant 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 Master of Science: Physician Assistant Program.

_____ _____

Signature of Healthcare Provider Date

Please include your official office stamp on this document

*If reasonable accommodations are requested for disabilities, please submit documentation of the disability to the Student Support Office.