INTERNATIONAL STUDENT CERTIFICATE OF HEALTH

Please complete and return to North Central Michigan College
NORTH CENTRAL MICHIGAN COLLEGE
Petoskey, Michigan 49770, U.S.A.

To be completed by a physician and sent directly to the International Student Advisor, North Central Michigan College, 1515 Howard Street, Petoskey, Michigan, 49770 U.S.A.

Full Name of Applicant:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Other Names</th>
<th>Family Name</th>
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Address:

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<tr>
<th>Number and Street</th>
<th>City</th>
<th>Country</th>
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</table>

Age: ___________ Nationality: ________________________________________

I. History

(a) Annotate with a mark (X) if applicant has/had any of the following; (If marked, please annotate date of positive findings):

( ) Rheumatic Fever ( ) Tuberculosis ( ) Lues
( ) Malaria ( ) G. C. ( ) Other____________

(b) Give details of any injury, illness, or operation during the past five years:

(Be sure to list all illnesses of injuries.)

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<tr>
<th>Injury/Illness/Operation:</th>
<th>From:</th>
<th>To:</th>
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(c) Annotate with a mark (X) only if any of the following apply to this applicant:

( ) Diabetes          ( ) Heart Condition          ( ) Epilepsy

( ) Hypertension      ( ) Blood Disorder          ( ) Lung Disease

If any of the above were checked, please explain briefly.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please indicate blood type: ___________

(d) Mental Status:

Please indicate if applicant has ever received treatment or counseling for any of the following:

( ) Emotional Disturbances          ( ) Nervous Disorders

( ) Mental Illness                  ( ) Behavioral Disorders

II. Summary

I believe this applicant (circle one) is is not physically able to carry on a full course of study, involving many hours of work in the United States. In my opinion, the applicant’s health and physical condition is:

( ) Excellent           ( ) Good           ( ) Fair           ( ) Poor

Additional Remarks
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signature of Examining Physician       Date

Please type:

Physician Name

Address          City          Country

International Area Code & Telephone Number