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:
North Central Michigan College
Office of the Registrar
1515 Howard Street
Petoskey, Michigan, 49770

Full Name of Applicant:

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

<table>
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<tr>
<th>Number and Street</th>
<th>City</th>
<th>Country</th>
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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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<thead>
<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 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: ____________________________________________