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:

First Name Other Names Family Name

Address:

Number and Street City Country

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.)

Injury/Illness/Operation: __________________ From: ___________ To ___________
(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: ____________________________________________