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|  | **PAACS HEALTH CERTIFICATE** *Instructions to candidate: Please fill out the first page, sign and print. Have physician fill out second page including results of laboratory tests and chest x-ray and sign. Scan completed form and send via e-mail to* *admissions@paacs.net**.* ***Any misleading or incorrect information may lead to*** ***non-acceptance or dismissal from the PAACS program.*** |
| Applicant’s name: |       | License # |       |
| Physician’s address: |       | Telephone: |       |
| Examining Physician Name: |       | Applicant’s Age: |       |
|  |  |  |
| **HISTORY** (to be completed by applicant) |  |
|  | Drug Name | Type of reaction |
| Allergies: |       |       |
|  |       |       |
|  |       |       |
|  | Drug Name | Dosage |
| Current Medications: |       |       |
|  |       |       |
|  |       |       |
|  |  |  |
| Tobacco use: | [ ]  Never [ ]  Have quit [ ]  Presently using (describe usage)  |       |
| Alcohol use: | [ ]  Never [ ]  Socially (describe usage)  |       |
|  |  |  |
| Do you experience: | [ ]  Chronic Cough [ ]  Hemoptysis [ ]  Night sweats [ ]  Weight loss > 5 kg in past year |
|  | Reason | Approximate Dates |
| Hospitalizations: |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  | Type of Surgery | Approximate Dates |
| Surgery: |       |       |
|  |       |       |
|  |       |       |
|  |       |       |
|  | Type | Date of last vaccination |
| Vaccinations: | Tetanus |       |
|  | Hepatitis B |       |
|  | Yellow Fever |       |
|  |  |  |
| Are you in good health? [ ]  Yes [ ]  No (please explain) |  |
|  |
|  |

***Affirmation by Applicant:***

 *I, Dr.* *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, PAACS applicant, affirm that the information on this form is true and accurate.*

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |
| --- | --- | --- |
| **Physical Examination** (to be completed by examining physician) | Date of exam  |       |
| Height (cm) |  | Weight (kg) |  | RespirationsPer min |  | BP |  | Pulse (beats per minute) |  |
| Skin and Hair:  | [ ]  Normal [ ]  Eczema [ ]  Scabies | Other or comments: |  |
| Head and Neck: | [ ]  Palpable lymph nodes: | Other or comments: |  |
|  | With glasses | Without glasses | Comments: |
| Vision – left eye |  |  |  |
| Vision – right eye |  |  |  |
|  |  |  |  |
| Hearing – Left ear [ ]  Normal [ ]  Diminished [ ] Poor [ ]  Absent Comments:  |  |
| Hearing – Right ear [ ]  Normal [ ]  Diminished [ ] Poor [ ]  Absent Comments:  |  |
| Chest Auscultation:  |  |
| Heart Auscultation: |  |
| Abdomen: | [ ]  Hepatomegaly [ ]  Splenomegaly | Comments: |  |
| Hernias | [ ]  Left [ ]  Right |
| Arms, hands, fingers | [ ]  Normal | Describe any variation from normal or any limitations |  |
| Legs, feet, mobility | [ ]  Normal | Describe any variation from normal or any limitations |  |
| Psychological status and mental stability | [ ]  Normal | Describe any variation from normal or any inappropriate behavior |  |
|  |  |  |  |
| **Required X-ray and Laboratory Examinations** |
| Test | Result |
| Fasting blood glucose |  |
| Hepatitis B antigen |  |
| HIV |  |
| VDRL (RPR) |  |
| Urinalysis: |  |
|  |  |
| Specific gravity |  |
| Red blood cells | [ ]  Negative |  |
| White blood Cells | [ ]  Negative |  |
| Sediments | [ ]  Negative |  |
| Glucose | [ ]  Negative |  |
| Protein | [ ]  Negative |  |
| Chest X-ray |  |

**AFFIRMATION:** (to be completed by the examining physician)

 *I, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that to the best of my knowledge this candidate*

 *(printed name)*

*is in excellent health and does not have a physical problem that would keep him in any way from meeting the demands of residency training program.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Examining physician’s signature)*