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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*](mailto: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) | |  | Respirations  Per 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)*