ST. LOUIS COLLEGE OF PHARMACY

UNIVERSITY OF HEALTH SCIENCES & PHARMACY

OFFICE OF EXPERIENTIAL EDUCATION

Dear Health Care Provider,

In order to comply with the requirements of some of our pharmacy experiential sites, this student needs a physical examination to participate in their clinical rotations. We receive no definitive guidelines from our experiential partners regarding the scope and depth of this examination, only that it be completed within a year of assignment to a particular site.

The attestation below is sufficient to document this requirement. Alternately we can accept your own form* or letter that must include:

- A statement noting that the student has undergone a physical examination and does not present apparent clinical contraindications to participate in clinical practicum experiences / rotations
- Student name and date of birth
- Date of physical exam
- Provider address and phone number
- Health Care Provider signature

**We cannot accept any forms that include specific medical information (e.g. history, diagnoses, recommendations, etc.).*

A copy of the physical exam should be on record and made available to the school at the request of the student if needed.

More information about our experiential curriculum is available at uhsp.edu/pharmd.

If you have any questions, please contact Dr. Nicole Gattas, director of experiential education, at nicole.gattas@uhsp.edu or 314.446.8555.

Office of Experiential Education
St. Louis Collee of Pharmacy at
University of Health Sciences and Pharmacy in St. Louis

Physical Examination Attestation Form

Student ____________________ ____________________ ____________________
Last First Middle

Student Date of Birth __________ ______ ______
Month Day Year

Attestation	☐ I examined the above-named student and completed a pre-participation physical examination on this date (within 12 months): ______/______/_______ ☐ The student does not present apparent clinical contraindications to participate in clinical practicum experiences / rotations. A copy of the physical exam is on record in my office and can be made available to the school at the request of the student.

Health Care Provider ____________________ ____________________ ____________________
Last First Middle

Clinic Address ____
Street

____________________ ____________ ________________
City State Zip Code

____
Telephone

Provider Signature ____ Date ______________