

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: _____

Injury/Illness/Operation: _____ From: _____ To: _____

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: _____