PHYSICIAN'S CERTIFICATE

To the applicant: This form must be completed by a physician familiar with your health and medical history, or on the basis of physical examination.

Applicant's Name _____

Physician's Name _____

Physician's Address _____

Street Address City State Zip

To the physician: The above person is applying to our Seminary. We ask your certification that the applicant is of sufficiently good health and fitness to attend the Seminary. We also wish to be informed of any serious medical condition, such as listed below, in case an emergency should arise during the program. Please return this form directly to Holy Trinity Orthodox Seminary. Thank you for your cooperation.

Does the applicant suffer from or have a history of any of the following conditions? If so, please check and comment legibly.

epilepsy	☐	heart disease, heart attack	☐
diabetes	☐	physical handicap	☐
serious food or drug allergies	☐	mental disorders	☐
asthma	☐	other (specify) _____	☐
gastric or intestinal disorders	☐	none of the above	☐

Immunization Record

(You must have all vaccinations to be accepted)

mumps	☐	(Date: mm/dd/yyyy) _____
measles	☐	(Date: mm/dd/yyyy) _____
rubella	☐	(Date: mm/dd/yyyy) _____

☐ I certify that the above applicant is in good health and physically fit. I see no obstacle to his or her participation in the program.

☐ For medical reasons, I do not recommend that the above applicant take part in the program.

_____

Signature of physician Seal Date

ANY HISTORY OF PHYSICAL OR MENTAL ILLNESS WHICH THE APPLICANT WITHHOLDS FROM THE PHYSICIAN MAKES THE APPLICANT WHOLLY RESPONSIBLE FOR THE STATE OF HIS OR HER HEALTH WHILE IN HOLY TRINITY SEMINARY.

_____

Signature of applicant Date

Please return to:
Holy Trinity Orthodox Seminary
PO Box 36
Jordanville. NY 13361
USA