Worsham College
of MORTUARY SCIENCE

CERTIFICATE OF HEALTH

APPLICANT: Complete the applicant section of this form. The provider who examines you MUST hold an active license in the jurisdiction in which they practice. Direct the provider to complete the Examining Provider Section of this form and **return the completed form to you for inclusion with your Application.**

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER — — — – — — – — — — —
4. ADDRESS STREET, CITY, STATE, ZIP CODE		
6. MAIDEN OR GIVEN SURNAME		

EXAMINING PROVIDER: **Complete the remainder of this form. Reference the above profession name to determine the appropriate statement to check-off. RETURN THE COMPLETED FORM TO THE APPLICANT. Physical examination must have occurred within the preceeding 12 months.**

A. PROVIDER NAME FIRST MIDDLE LAST	B. PROVIDER LICENSE NUMBER
C. STREET ADDRESS	D. STATE OR TERRITORY OF LICENSURE
E. CITY, STATE, ZIP CODE	F. DATES OF APPLICANT'S PHYSICAL EXAMINATION OR IMMUNIZATION

STATEMENT II: COMPLETE THIS STATEMENT FOR THE

FUNERAL SERVICE AND MORTUARY SCIENCE STUDENT

The above-named applicant received the following:
1)Diptheria-Tetanus (adult type) immunizations ☐ Booster
2)Hepatitis B ☐ Series

I hereby declare that the above information is true and correct.

Signature _____ Date _____