SAN JOSÉ STATE UNIVERSITY

KAY ARMSTEAD CENTER FOR COMMUNICATION DISORDERS
Connie L. Lurie College of Education · Department of Communicative Disorders and Sciences
One Washington Square · San José, CA 95192-0079 · Main: (408) 924-3659 · Fax: (408) 924-3641

COUNCIL ON ACADEMIC ACCREDITATION IN SPEECH-LANGUAGE PATHOLOGY

PHYSICIAN'S CLEARANCE

Student's Name: _____ **Date of Birth:** _____

Medical Provider: _____

Provider's Address: _____
Street Address City State Zip

Physician's Name: _____

SECTION BELOW IS ONLY TO BE COMPLETED BY THE MEDICAL PROVIDER AND/OR PHYSICIAN.

To Whom It May Concern:

_____ was seen in my office on _____ for a standard physical.
Full Name of Patient Date: MM/DD/YYYY

This patient appears to be _____ (Please check one of the boxes box below.) _____ .

☐ in good health and is fit to work with clients.

☐ in poor health and needs to seek medical assistance. This student is not fit to work with clients.

☐ other (please see below for my comments).

Respectfully,

_____ _____
(Physician's Signature – **REQUIRED**) (Date: MM/DD/YYYY)

_____ _____
(Physician's Printed Name) Physician's Contact Information (phone or email)

OPTIONAL: Please place official seal or stamp of hospital or physician above.

Additional Comments/Notes: _____