



Last Name: _____ First: _____ Middle: _____

DATE OF EXAMINATION: _____ DATE OF REPORT: _____

I HAVE EXAMINED _____ AND FIND HIM/HER TO BE
PHYSICALLY CAPABLE OF PERFORMING THE DUTIES OF AN EMERGENCY
MEDICAL TECHNICIAN (EMT) AS STATED IN THE MITCHELL COMMUNITY
COLLEGE PHYSICIAN OVERVIEW DOCUMENT.

_____ YES

_____ NO

THE EVALUATION PERFORMED TODAY ON THIS EXAMINEE INCLUDED A
PHYSICAL EXAMINATION BY A LICENSED PHYSICIAN, NURSE PRACTITIONER
(NP), OR PHYSICIAN ASSISTANT (PA)

PHYSICIAN, NP, or PA INFORMATION

NAME _____ STATE LICENSE # _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE # () _____

DATE OF REPORT _____

SIGNATURE OF PHYSICIAN, NP, or PA _____