



Master of Athletic Training

PHYSICAL EXAMINATION VERIFICATION

To be completed by applicant *(Please type or print)*

Last Name

First Name

Middle Initial

Date of birth (month, day, year)

Do you have any health problems or concerns that you would like to discuss today?

Yes

No

Applicant Signature

Date

To be completed by physician

A thorough history and physical examination were completed on the above named individual, with the following results:

- ☐ All findings were within normal limits
- ☐ Follow-up care is required; patient was advised

Comments: _____

Physician signature

Printed Name

Date

Facility name (please print)

Office phone number

Address

*Please submit completed form to the Office of Graduate Studies, gradstu@uwgb.edu or Office of Graduate Studies, 2420 Nicolet Drive, Green Bay, WI 54311-7001.