



St. Martinus University,

Faculty of Medicine

PHYSICAL EXAMINATION FORM

Dear Doctor:

The bearer of this form has applied for admission to the above named University. The laws of the country in which it is located require that he/she had a physical examination within the past six months before admission can be granted. Please complete this form and return it to the applicant. You may use an equivalent form of your own if you prefer. (Completion of this form is at the expense of the applicant)

I hereby certify that I am a physician duly licensed to practice medicine in _____ (state or country) and that I have personally examined _____ (name of applicant).

I. Physical Examination:

Height _____ ft. Weight _____ lbs.

BP R Arm _____ L Arm _____ Pulse _____ Allergies _____

HEENT _____

Chest _____

Abdomen _____

Extremities _____

Genitalia _____

Mental Status _____

Condition (s) for which currently being treated _____

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Please describe any uncorrectable disabilities in his/her perception, intellect, personality, communication, manipulation or ambulation that might limit or interfere with his/her educational participation with that of his/her classmates:

Other

Name of Physician

Address

Telephone Number

Email Address

Physician's Signature

Date