



*Certificate of  
Medical Examination*

To be completed by Physician and returned to:

**Director of Admissions  
Faith School of Theology  
29 Main Road  
Charleston, ME 04422**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip*

I certify that I have examined the above named applicant on: \_\_\_\_\_  
*Date*

and found him/her to be of sound mental and physical health, free from communicable disease or physical defect which might interfere with his/her success at Faith School of Theology.

Please list any existing ailments and Rx for existing ailments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please supply Immunization record (if available).

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip*

Physician's Telephone Number (\_\_\_\_) \_\_\_\_\_