



*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 (____) _____