Doctor of Occupational Therapy Program Participation Clearance

Name:____

DOB: ____

Date of Physical Examination: ____

________I certify that the above-named patient is able to participate in the full extent of the Southern California University of Health Sciences Doctor of Occupational Therapy Program and meets the Technical Standards set forth by the program.

________I certify that the above-named patient is able to participate in the Southern California University of Health Sciences Doctor of Occupational Therapy Program but will require reasonable accommodations to meet the Technical Standards set forth by the program.*

________I certify the above-named patient is not cleared to participate in the Southern California University of Health Sciences Doctor of Occupational Therapy Program.

______________________________ ______________________________

Signature of Healthcare Provider Date

Please include your official office stamp on this document