



**MARQUETTE  
UNIVERSITY**

**Required Annual Physical Screening Exam**

**Student Name** \_\_\_\_\_

**This is to verify that the above student is “in good health and free of any communicable diseases”.**

**PLEASE PRINT**

**Health Care Provider** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Phone** \_\_\_\_\_

**Date** \_\_\_\_\_

**Return to the Director of Clinical Education, Marquette University, PA Studies  
Fax (414) 288-7951**

**Rev 4/09**