SCHOOL OF KINESIOLOGY
INTRAOPERATIVE NEUROMONITORING PROGRAM
UNIVERSITY OF MICHIGAN

PHYSICAL EXAMINATION FORM

TO BE FILLED OUT BY THE STUDENT

First Name	Last Name	UM UD	
Uniqname	Phone Number	DOB	Sex
Address	City	State	Zip

TO BE FILLED OUT BY HEALTHCARE PROVIDER

Temperature	Pulse	Respiratory Rate	Blood Pressure

EXAMINATION	NORMAL	ABNORMAL	COMMENTS
Head, Neck, and Thyroid			
Nose and Sinuses			
Mouth, Throat, Teeth, and Gums			
Eyes			
Ears			
Skin			
Chest and Lungs			
Heart and Vascular System			
Gastrointestinal System and Abdomen			
Musculoskeletal System and Extremities			
Neurological			
Mental Health			

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I have given the student a complete physical examination. I feel that he/she is physically and mentally capable of participating without hazard in clinical practice settings for the University of Michigan School of Kinesiology IONM Program.

Healthcare Provider's Name and Title (Please Print)

Healthcare Center/Facility

Healthcare Provider's Signature

Address, City, State, Zip

Date

Phone Number

Updated August 2016