COLUMBIA
COLLEGE OF NURSING

4425 North Port Washington Road Glendale, Wisconsin 53212 Phone: (414) 326-2330 Fax: (414) 326-2331
www.ccon.edu

HEALTH CONDITION CERTIFICATION FORM

I am aware that my patient, ___________________________________, is a student enrolled in
(Student Name)

the Columbia College of Nursing Program. I certify that he/she is under treatment for

____.

Further, I am aware that this individual is involved in direct patient care for up to 20 hours per week, and he/she has additional hours in the classroom setting.

I certify that, to the best of my knowledge, this student's medical/mental health condition/treatment will not affect and/or limit his/her ability to perform safely in the classroom and/or clinical setting in any way, nor does such participation compromise the student's own physical/mental health. ***This student may return to the following activities without restrictions:***

Clinical ____________________________________
Physician or Nurse Practitioner Signature

Laboratory ____________________________________
Physician or Nurse Practitioner Signature

Classroom ____________________________________
Physician or Nurse Practitioner Signature

____ ______________
Name of Physician or Certified Nurse Practitioner Date
(Please print or type)

____
Address

____
City State Zip Code

____
Telephone

Revised February, 2012