NEW ORLEANS BAPTIST THEOLOGICAL SEMINARY
DIVISION OF CHURCH MUSIC MINISTRIES

Health Certificate

FULL LEGAL NAME Last _____ First _____ Middle _____

CURRENT MAILING ADDRESS _____

BIRTH DATE Month _____ Day _____ Year _____ NOBTS-ID _____

I hereby authorize Dr. _____ to release the information contained in this medical form which is required for admission to New Orleans Baptist Theological Seminary.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

NOTE TO THE EXAMINING PHYSICIAN

The purpose of this form is threefold: (1) Seminary responsibilities are very strenuous. In addition to carrying a heavy load of studies, a student often has to work to support himself or herself. To be sure that the student is physically and emotionally competent to carry such a load, we need a medical evaluation of the applicant. (2) At the Seminary we offer a limited health service (resident campus physicians who conduct regular clinics and a resident nurse who arranges for treatment of emergency cases). Important points (if any) in the applicant's medical history will be helpful in this connection. (3) To comply with the immunization laws of the state of Louisiana, proof of immunization is required by all applicants.

1. Please indicate the nature of the applicant's relationship with you as a physician.

   ☐ Regular patient ☐ Occasional patient ☐ First visit

2. Significant points (if any) in the applicant's family medical history:

3. Significant points (if any) in the applicant's past medical history:

4. Remarkable points in the applicant's personal and social habits–alcohol, stimulant or sedative drugs, or any other abnormal physical findings:

5. Psychiatric history or prevailing conditions, if any:

6. In your professional opinion, what factors in the patient's medical or psychiatric status might interfere with his or her carrying a full load of studies and with working to support himself or herself if necessary while at the Seminary?

7. Is the applicant at this time postponing any necessary medical and surgical treatment?

8. Other remarks:

NAME OF PHYSICIAN (printed or typed) _____

ADDRESS OF PHYSICIAN (printed or typed) _____

SIGNATURE OF EXAMINING PHYSICIAN _____

DATE OF EXAMINATION _____