SkillsUp Healthcare Institute
101 Route 130 S, Suite 207
Cinnaminson, NJ 08077
Phone: (856) 577-5363 | Email: admin1@suhcinstitute.com

Medical Clearance for School and Clinical Participation

Student Name: _____

Date of Birth: ___ / ___ / ____

This student is scheduled to participate in classroom and clinical training for the Certified Nursing Assistant (CNA) program at SkillsUp Healthcare Institute.

Please complete the section below to verify the student's ability to safely engage in training activities, including lifting, standing for extended periods, and direct patient care.

☐ I certify that the above-named individual has been examined and is medically cleared to participate in school and clinical activities without restrictions.

☐ I certify that the above-named individual is NOT cleared to participate due to medical concerns.

Physician/Provider Name: _____

Practice/Facility: _____

Phone: _____

Provider Signature: _____ Date: ___ / ___ / ____

Provider Stamp: _____