**HEALTH QUESTIONNAIRE - (To be completed by the applicant)**

Do you have any physical limitations which would affect your ability to lift, turn, or transfer patients?

Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Do you have any limitations in the use of your senses, such as sight, speech, or hearing, which would limit your ability to practice a health profession? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Do you have any other condition which might interfere with your ability to practice a health profession? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_

If you have answered "yes" to any of the above, please attach an explanation of your limitations.

I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS COMPLETE AND ACCURATE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last, First Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date