FIVE BRANCHES UNIVERSITY
Graduate School of Traditional Chinese Medicine

Health Evaluation

The applicant as identified below has applied to the Five Branches University Master of Traditional Chinese Medicine program. Successful completion of the program allows students to take the California state licensing examination and become primary health care providers. In order to ensure that safety precautions are maintained in the Five Branches clinic and to maintain a healthy environment on campus we require the completion of a Health Evaluation, signed by a qualified, primary healthcare practitioner (not employed by Five Branches). All information provided will be held strictly confidential.

Applicant Information (To be completed by Applicant)

Name (Print clearly) _____ Social Security Number _____

Date of Birth _____ Five Branches campus you are applying to _____

Healthcare Practitioner Evaluation (To be completed by Healthcare Practitioner)
When answering the following questions please keep in mind that the course of study at Five Branches is very physically, emotionally and mentally demanding, equivalent to the demands of medical school and internship. Attach additional pages as necessary.

Does the applicant show any current sign of, or have a known history of any mood or thought disorders such as severe depression, manic depressive disorder, ADHD, schizophrenia, or schizo-affective disorders? ☐ No ☐ Yes If yes, please explain:

_____

Does the applicant show any current sign of, or have a known history of substance abuse, such as cocaine, heroine, methamphetamines, marijuana or alcohol? ☐ No ☐ Yes If yes, please explain:

_____

Does the applicant have any current health problems or a history of health problems that may interfere with or otherwise affect their ability to participate in courses and/or clinical practice at Five Branches University? ☐ No ☐ Yes If yes, please explain:

_____

Does the applicant have any current communicable diseases or other current conditions, or history of conditions that may affect their participation in Five Branches University lecture or practical courses?☐ No ☐ Yes If yes, please explain:

_____

Healthcare Practitioner Information

Practitioner's Name (Print clearly) _____ Title _____ License # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email Address _____

I hereby certify that I have thoroughly evaluated the applicant and that all statements made are true and accurate:

Healthcare Practitioner Signature _____ Date _____

Healthcare Practitioner: Please mail directly to the appropriate Five Branches University campus, Attention: Admissions Office.

Santa Cruz Campus
200 Seventh Avenue, Santa Cruz, CA 95062 USA
(831) 476-9424 ▪ Fax: (831) 476-8928
admissions@fivebranches.edu

San Jose Campus
1885 Lundy Ave, Suite 108, San Jose, CA 95131 USA
(408) 260-0208 ▪ Fax: (408) 261-3166
sjadmissions@fivebranches.edu