

**California State University, Los Angeles/California State Polytechnic University, Pomona  
Clinical Laboratory Scientist Training Program  
Clinical Genetic Molecular Biology Scientist Training Program**

**Statement of General Health**

The Program requires a statement of your general health from your medical health care provider (physician, physician assistant or nurse practitioner).

Please have your medical health care provider complete this form and **mail it to the institution** within three months of beginning the CGMBS Training Program. This statement will become part of your permanent school record. Please fulfill this requirement as soon as possible.

Student's name:

\_\_\_\_\_ Print \_\_\_\_\_ Signature

Return to: Nancy McQueen, Program Director  
California State University, Los Angeles  
Clinical Laboratory Scientist Training Program  
5151 State University Drive  
Los Angeles, CA 90032

Phone: (323) 343-2052

**Special considerations beyond the need for good general health**

Is the trainee capable of the required manual dexterity required for the performance of clinical laboratory testing (pipetting, manipulating large and small objects, operating a computer keyboard) and does the trainee have the visual ability to distinguish between colors, read small numbers, distinguish between clear, opaque, and particulate solutions? \_\_\_ Yes \_\_\_ No

Please list all medications currently being taken by the student.

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

Health Care Provider's Statement of General Health:

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

Are there any physical or mental health problems that may affect progress in the educational program for the Clinical Genetic Molecular Biology Scientist or participation in the clinical activities both as a student and upon graduation and employment in a clinical setting? \_\_\_ Yes \_\_\_ No

If yes, please explain below.

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

Name of Health Care Provider (print or type) \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

\_\_\_\_\_ Provider Signature \_\_\_\_\_ Date