

Nicola Valley Institute of Technology

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MEDICAL REFERENCE FORM Aboriginal Early Childhood Education Program

PERSONAL INFORMATION OF APPLICANT

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (YY/MM/DD) ___/___/___ Email address: _____ Phone: (____) ____ - ____

Address: _____

PHYSICIAN INFORMATION (to be completed by Physician)

The following questions are to be answered by the Physician:

1. How long have you known this patient? _____
2. Date of last medical exam? _____
3. With your knowledge of the above mentioned patient, do you feel that s/he is physically and emotionally able to take on the responsibilities of caring for small children? YES NO
4. Are you aware of any condition which may restrict the patients ability to fulfill the responsibility of caring for small children? If so, please describe in detail: _____

5. Being aware of the program requirements (as described in the medical information form), I believe the patient is:
 Fit / Unfit to undertake this training.

Physician Signature: _____ Date: _____ Phone: (____) ____ - ____

Name & Address of Organization

Office Use Only

* Please submit completed form to the office of the Registrar at the address above.