



Capital College

4400 Hazelbridge Way Unit 540, Richmond, B.C. Canada V6X 3R8

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PHYSICIAN'S DECLARATION

Student's Name: _____

Address: _____

This is to certify that I have examined the above named person and find that she/he is mentally and physically fit to provide care for a group of young children.

Date of Last Medical: _____

How long have you known this patient: _____

Additional Comments: _____

Physician's Signature

Physician's Name

Date

Address: _____

Phone No: _____

Please return to:

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