Cuyahoga Community College

HEALTH INSURANCE ATTESTATION

Student Name: _____

Name of Insured: _____

Relationship to Insured: _____

Insurance Provider: _____

Policy Number: _____

Group Number: _____

I certify by my signature that this information is true. I _____, attest that as required by law, I have a current health insurance plan which I will maintain through the entirety of the health career program. I understand that I am required to present proof of my health insurance plan to a clinical agency or Cuyahoga Community College immediately upon request.

Student's Signature:

Printed Name: _____ **Date:** _____

Cuyahoga Community College

HEALTH RELEASE FORM

This is to certify that_____had a physical exam on_____and is in apparent good health, has no condition that would endanger the health and well-being of other students or patients, and is physically/ mentally able to participate in a Health Career/Nursing Program at Cuyahoga Community College.

Provider Signature: _____

Provider Printed Name:_____

Provider Address:_____

Provider Phone Number:_____

I certify by my signature that this information is true and that I can provide documentation upon request.

Student Signature:_____**Student**

Printed Name:_____**Date:** _____