COLORADO SCHOOL OF TRADITIONAL CHINESE MEDICINE

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Send To: **Colorado School of Traditional Chinese Medicine**
1441 York Street, Suite 202
Denver, CO 80206-2127
Attn: Timothy Farad

To Whom It May Concern:

I, ______________________(Please Print Practitioner's Name)**, have examined the patient ______________________**(Student's Name)**. I find this patient to be of sound mind and body, physically and emotionally able to undertake the scholastic program at CSTCM.**

Sincerely,

______________________ ______________________
(Practitioners Signature) **(Credentials)**

______________________ ______________________
(Type of Practice) **(License Number)**

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Date

Doctor's and patient's please note:
We will not accept Xerox or faxed copies of this document. The hardcopy original containing the doctor's signature must be returned to the Colorado School of Traditional Chinese Medicine. All areas must be filled out completely.