TECHNICAL STANDARDS CERTIFICATION STATEMENT
The Ohio State University
School of Health & Rehabilitation Sciences
Athletic Training Division

This form is a companion to the Technical Standards for Athletic Training Students document that can be found online at http://medicine.osu.edu/hrs/at/current-students/technical-standards. After being accepted for admission to the Athletic Training Educational Program, students must complete and submit this certification form to the Ohio State University Division of Athletic Training prior to beginning the program's professional courses or clinical practice activities. Submit a photo or scan of the signed and completed form electronically into your E*Value account (https://www.e-value.net/login.cfm).

Enrollment of accepted students in the Athletic Training Educational Program is contingent upon all of the following:

1. Submission of the acceptance form and fee (if applicable) to the Office of Professional Admissions.
2. Submission of this completed Technical Standards Certification Statement to the Division of Athletic Training;
3. The ability to meet the Technical Standards for Athletic Training Students either with or without accommodation;
4. The verification of the physical aspects of this ability as determined through a routine physical examination by a healthcare provider licensed and qualified to perform such routine physical examinations (typically a physician, physician assistant or advanced nurse practitioner).

   a. Provide a copy of the Technical Standards for Athletic Training Students document to the healthcare provider.
   b. The signature of the healthcare provider completing the physical examination must appear on this form (see below).

STUDENT STATEMENT:

After you have been accepted into the program, check only one of the boxes below and sign where indicated:

☐ I certify that I have read and understand the Technical Standards for Athletic Training Students document, and I believe to the best of my knowledge that I meet each of these standards without accommodation. I also understand that if I am unable or become unable to meet these standards with or without accommodation, I can not enroll or remain enrolled in the Athletic Training Education Program.

☐ I certify that I have read and understand the Technical Standards for Athletic Training Students document, and I believe to the best of my knowledge that I can meet each of these standards with accommodations. I will contact the Office for Disability Services (150 Pomerene Hall, 1760 Neil Ave., 614-292-3307) to have my need for accommodation validated. I will work with both ODS and the Athletic Training Division to examine accommodation options. I understand that in some cases accommodation might not be possible. I also understand that if I am unable or become unable to meet these technical standards with or without accommodation, I can not enroll or remain enrolled in the Athletic Training Education Program.

________________________________________________
Signature of Student

________________________________________________
Date

VERIFICATION BY HEALTHCARE PROVIDER

Check only one of the boxes below and sign where indicated:

☐ I certify that I have examined the above named student and that I found no obvious conditions that would prevent him/her from meeting the physical portion (Standards 1 – 4) of the Technical Standards for Athletic Training Students outlined on the document accompanying this form.

☐ I certify that I have examined the above named student and that I found a condition(s) that might prevent him/her from meeting the physical portion (Standards 1 – 4) of the Technical Standards for Athletic Training Students outlined on the document accompanying this form. I recommend that the student contact the University’s Office for Disability Services to discuss accommodation options.

List condition(s) (use back of form if additional space is required):

________________________________________________
________________________________________________

Signature of Healthcare Provider
(Physician, PA, or Advanced Nurse Practitioner)

________________________________________________
Date