AFRICA UNIVERSITY
(A United Methodist-Related Institution)

STUDENT HEALTH SERVICE

X-RAY REPORT

Name: .....

Date of Birth: .....**Marital Status**.....

Sex: ..... **Nationality** .....

Faculty: .....

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.....

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.....

.....

I certify that I have X-rayed _____ **on the**
CLIENT'S NAME

_____ **His/Her X-ray number is** _____ **and I certify**
DATE

that there is/there is no evidence of active tuberculosis in the lung fields.
(delete inapplicable)

Reported by: _____ _____ _____
NAME (Please Print) **SIGNATURE** **DATE STAMP**

Qualifications: _____

"FAILURE TO PROVIDE THE DETAILS AS INDICATED ABOVE MAY RESULT IN THE PROSPECTIVE STUDENT'S APPLICATION BEING DISQUALIFIED"