CEDAR CREST ATHLETIC TRAINING

GO FALCONS

CEDAR CREST HIGH SCHOOL 115 E. EVERGREEN RD LEBANON PA 17042

2020-2021

SPORTS PIAA PHYSICAL PACKET
****PLEASE READ AND COMPLETE THIS PACKET COMPLETELY****

DEAR PARENTS AND GUARDIANS: This packet was developed to make the physical examination process easier for both you and the athletic department.

******PLEASE BE SURE TO FILL OUT ALL INFORMATION AND USE ONLY BLUE OR BLACK PEN.******
INCOMPLETE PHYSICAL PACKETS AND/OR
PHYSICAL PACKETS FILLED OUT IN PENCIL WILL NOT BE ACCEPTED

Student-athletes who will be getting a physical at Cedar Crest High School:

- Physicals will be given for **a Fee 15.00** at Cedar Crest High School Gym B
  - **Thursday July 30, 2020 3:00 PM - 6:00 PM.**
  - **Tuesday Aug. 4, 2020 6:00 PM - 9:00 PM**
  - **Thursday Aug. 6, 2020 3:00 PM - 6:00 PM**
    - Please complete Sections 1-5 and sign at the appropriate places.

    No athlete will receive a physical without having Sections 1-5 completed and proper signatures.

Student-athletes who will be getting a physical by their Primary Care Physician:

- Authorized Date of Physical must be dated after **May 31, 2020**.
- The entire Physical Packet must be turned into the **Athletic Office at the High School** prior to the start date of the sport season.
  - At the latest,
    - Fall Season: August 7 2020,
    - Winter Season: November 13, 2020
    - Spring Season: February 26 2021

DO NOT TURN PHYSICAL PACKET INTO YOUR COACH. ALL PACKETS MUST GO TO THE HIGH SCHOOL ATHLETIC OFFICE, OR TO THE ATHLETIC TRAINER. THE ATHLETIC OFFICE WILL BE OPEN FROM 7AM-3PM DURING THE SUMMER MONTHS

Athletes with known cardiac conditions: If you are getting a physical done at the high school on one of the above-mentioned dates; please provide the doctors a note from your most recent cardiac evaluation at the time of your physical. This will help the physicians. If you are NOT getting a physical done at the High School, but have a known cardiac condition, or have been evaluated for a heart murmur, etc. you must provide the athletic department with an up to date clearance note from your cardiologist.

Athletes who use an inhaler, Epipen, insulin/pump, or any other medication: In accordance with the Pennsylvania Board of Medicine and Osteopathic Medicine, your child must have a physician's note or the school medication form, which requires both the physician's signature and parents signature, giving permission to self-administer his/her inhaler or medication during extra-curricular activities. The note must include athlete's name, medication type, and dosage/frequency amounts with the authorization to self-administer. A copy of this authorization will be kept on file in the Athletic Training Room. We do not have access to 504 plans or IEP's, if this is the case for your child we still need a separate physician's note. **If there are any other medical concerns that may be in a 504 plan or IEP that would help in a medical capacity please indicate on section 1of the PIAA form at student health conditions**

Cell (717)454-6150 Fax (717) 389-1880 Office (717) 272-2033 ext 5956
cseldomridge@clsd.k12.pa.us

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1, 2016 and shall be effective, regardless of when performed during a school year, until the next May 31st.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will the determine whether Section 8 need be completed

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

ALL FIELDS MUST BE COMPLETED, INDICATE N/A IF FIELD DOES NOT APPLY
Must be completed in BLUE or BLACK Pen ONLY, NO PENCIL

Athlete's Last Name(s): _____ First Name:_____Male/Female

Grade for **2020-2021** School Year (circle one) **7 8 9 10 11 12** Date of Birth: ____/____/____

Age of Student:_____ Graduation Year:_____ Home Phone# (N/A if no home phone) (717)_____

Current Home Address _____

YOU MUST INDICATE A SPORT, DO NOT PUT A CHECK MARK OR LEAVE BLANK

Fall Sport(s):_____Winter Sport(s):_____ Spring Sport(s):_____.

IN CASE OF AN EMERGENCY PLEASE INDICATE WHO SHOULD BE CONTACTED 1ST,2ND,AND 3RD. 1ST CONTACT NEEDS TO BE A PARENT OR GUARDIAN. PLEASE PROVIDE AT LEAST 2 DIFFERENT CONTACTS AND 2 DIFFERENT CONTACT PHONE NUMBERS

1st Contact: _____
First Name Last Name(s) Phone Relationship

2nd Contact: _____
First Name Last Name(s) Phone Relationship

1st Contact email address:_____2nd Contact email address_____

ALL INFORMATION BELOW MUST BE COMPLETED OR INDICATE N/A:

Family Physician's Name/Group:_____, MD or DO (circle one) Telephone # ( ) _____

Dentist Name/Group:_____Telephone # ( ) _____

Preferred Hospital: _____

Student's Allergies_____

Student's Health Condition(s) of which an Emergency Physician Should be Aware (Asthma, ADHD, ect)_____

_____

Student's Prescription Medications_____

_____

Is the above-mentioned student athlete currently covered by medical insurance? YES or NO.

I hereby certify that to the best of my knowledge all of the information in Section 1 is true and complete.

Parent's/Guardian's Signature _____Date____/____/_____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

THE STUDENT'S PARENT/GUARDIAN MUST COMPLETE ALL PARTS OF THIS FORM.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of Cedar Crest _____School and a resident of the Cornwall-Lebanon School District (CLSD) to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 2020-2021 school year in the sport(s) as indicated by my signature(s)following the name of the said sport(s) approved below.

SIGNATURE(S) REQUIRED, NOT A CHECK MARK

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Cheerleading	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Cheerleading	
Rifle	Not Offered at CLSD
Swimming and Diving	
Track & Field (Indoor)	Not Offered at CLSD
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____Date____/____/_____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____Date____/____/_____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____Date____/____/_____

E. Permission to administer emergency/ medical care: I consent for a medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Additionally, I authorize a licensed medical provider to evaluate, treat, and rehabilitate injuries under the supervision of the District team physician or the athlete's physician's direction. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature _____Date____/____/_____

F. Confidentiality Statement: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature _____Date____/____/_____

G. Understanding the Re-certification Process: Any time your son or daughter is seen by a physician, a Re-Certification form will need to be completed and signed by the treating physician. This is Section 8 of the CIPPE form, which is available in the Athletic Trainer's Office, or on the Cornwall – Lebanon School District website.

Parent's/Guardian's Signature _____Date____/____/_____

H. Understanding Sports Insurance Policy: The Cornwall- Lebanon School District provides an all sports insurance policy to cover all senior high and middle school athletes, including cheerleaders & band members. This is considered secondary insurance for those students who are covered under another insurance plan. In the event of a sports related injury, the injury **MUST** be reported **IMMEDIATELY** to the appropriate school official; this will be the Athletic Trainer or Athletic Director. Insurance paperwork must be returned within 90 days of date of injury.

Parent's/Guardian's Signature _____Date____/____/_____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?

A concussion is a disturbance in brain function that occurs following either a blow to the head or as a result of a violent shaking of the head. A concussion…

- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?

Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately notify their Athletic Trainer, Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately notify their athletic trainer and/or coach.

- **The student should be evaluated** by his/her athletic trainer and a licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management. Cornwall- Lebanon School District (CLSD) Athletic Team Physicians and Certified Athletic Trainers will evaluate all head injuries for the evidence of a concussion. The CLSD and the CLSD Physicians are responsible for the health and safety of all student athletes. In occasional instances this may require superseding your physician's recommendations. The CLSD Sports Medicine staff will follow a stepwise return to play procedure for all concussions beginning with removal from play, appropriate treatment until symptom free, and eventual stepwise progression back to play. The procedures are recognized by the PIAA's Sports Medicine Advisory Committee as well as by National and International conferences on concussion management as appropriate standards of care.

- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long-term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  - The right equipment for the sport, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time the student Practices and/or competes
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____Date____/____/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature _____Date____/____/_____

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- · dizziness
- · lightheadedness
- · shortness of breath
- · difficulty breathing
- · racing or fluttering heartbeat (palpitations)
- · syncope (fainting)
- · fatigue (extreme tiredness)
- · weakness
- · nausea
- · vomiting
- · chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may also hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

_____ _____ Date____/____/_____

Signature of Student-Athlete | Print Student-Athlete's Name

_____ _____ Date____/____/_____

Signature of Parent/Guardian | Print Parent/Guardian's Name

Student's Name _____ Age_____ Grade_____

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2. Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes		
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐

	Yes	No
23. Has a doctor every told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you ever had a herpes skin infection?	☐	☐
CONCUSSION OR TRAUMATIC BRAIN INJURY		
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Do you experience dizziness and/or headaches with exercise?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you unhappy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY	☐	☐
47. Have you ever had a menstrual period?	☐	☐
48. How old were you when you had your first menstrual period?	_____	
49. How many periods have you had in the last 12 months?	_____	
50. Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____Date____/____/_____

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SP (circle one) Certification Date of CIPPE ___/___/___

Must be dated after 5/31/2020