



**Medical Examination
Form G**

In accordance with Canons of the Episcopal Church, Title III

**Send To: Holy Orders File
Episcopal Church in Minnesota
1101 W. Broadway Avenue
Minneapolis, MN 55411**

Name: _____ Date of Birth: _____

Address: _____

City/State/ZIP: _____

Cell/Home/Work: _____

Email: _____

FOR PHYSICIAN TO COMPLETE:

Physician Name & Clinic: _____

Address: _____

City/State/ZIP _____

Telephone (including Area Code): _____

RECOMMENDATION:

On the basis of my examination, is the candidate free from any medical condition or other impediment that would render him/her unsuitable for the tasks of ordained ministry?

Yes No With Reservations (If you have any confidential information that would render the candidate unacceptable, please so indicate here and forward details to the Bishop by confidential communication.)

Physician Signature

Date