Medical Evaluation
Form 3
In accordance with Canons of the Episcopal Church, Title III

Email preferred:
File Name: [Last Name] Form 3
File Type: PDF
holyorders@episcopalmn.org

Or mail:
Holy Orders File
The Episcopal Church in MN
1101 W. Broadway Avenue
Minneapolis, MN 55411

Name:_____ Date of Birth:_____/_____/_____

Address:_____

City/State/ZIP:_____

Primary Phone: _____-_____-_____

Email:_____

FOR PHYSICIAN TO COMPLETE:

Physician Name & Clinic:_____

Address:_____

City/Sate/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