

CAPELLI ACADEMY

80 Rorie Street Winnipeg, Manitoba R3B 3L6
Telephone (204) 452-7380 Fax (204) 284-1355

Medical Report

(To be completed by your doctor and returned with your enrollment contract)

Date _____

Student's Name _____ Date Of Birth _____

Address _____ City _____

Province _____ Postal Code _____

I have examined the above-mentioned patient and hereby certify that he/she is free from communicable diseases and fit to undertake training at **CAPELLI ACADEMY**, Academy of Hairstyling & Esthetics.

Signature Of Physician _____

Address _____

Telephone _____

Student Signature _____