HEALTH STATEMENT

Employee Name: _____

STATEMENT OF PHYSICAL HEALTH

The above named individual has been examined by me and found to be in good health, has no signs or symptoms of communicable diseases, and is able to perform the functions of the position without physical or mental restrictions as a health care professional.

	◯ MD ◯ DO ◯ NP ◯ PA
Signature	Title of Provider (Please Check)
Printed Name	Exam Date

OFFICE ADDRESS: (Please Print)

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

Office Phone Number: _____ **Office Fax Number:** _____