

Physician/Practitioner Health Statement

Employee Name: _____

SSN: _____ Date of Birth: _____ Job Title: _____

Physician/Practitioner Statement of Health

I have examined the above named patient and found them to be in good physical and mental health, free of communicable diseases and able to function without limitation as a healthcare professional.

Notes/Comments from Physician/Practitioner (if needed):

If any immunizations and/or labs (titres) were completed today that are related to this person's employment, please send copies along with this Health Statement.

Physician/Practitioner Name (PRINTED): _____

Physician/Practitioner Signature: _____

Date of Examination: _____

Please provide office ADDRESS OR include official STAMP:

Address: _____

Address: _____

Phone: _____

City, State, Zip: _____



PLEASE FAX BACK TO MEDICAL SOLUTIONS: 1-866-688-5929