# Statement of Health

**Authorization for Medical Information Release**
**( * To be Completed By Contractor * )**

I, _____ , do hereby authorize the below named healthcare provider to release any information acquired during my medical examination to Relieve Staffing, LLC, its partners and affiliates. I authorize permission to release any information on this statement that is relevant to employment to any of the facilities they provide services.

Skill: _____ (CNA, LPN, RN etc.)
License #: _____
State Licensed In: _____

Contractor Signature: _____
Date: _____

**Statement of Physical Health**
**( * To be Completed By Provider of Examination *)**

I have examined the patient and determined that this person is in good physical and mental health, free of communicable diseases and able to function and perform all job duties without any physical limitations in his/her profession at full capacity

Provider Name: _____
License #: _____
State Licensed In: _____
Nurse or Physician? : _____

Provider Signature: _____
Date: _____

Healthcare Provider Address:
Street: _____
City: _____
State: _____
Zipcode: _____
Phone #: _____


RELIEVE STAFFING, LLC
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