PHYSICIAN'S STATEMENT

(PLEASE PRINT CLEARLY)

Employee/Applicant Name:

NAME:_____________________________________ DOB: __________________________

HEIGHT:_______________ WEIGHT:__________VITAL SIGNS BP__,T___, P___,R___

Statement of Health

(To Be Completed By Physician)

I have examined the individual named above and to the best of my knowledge he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity. By signing below I certify that the above information is true.

Name (Printed): ____

Physician Signature: ____

Office Phone Number: ____

Date of Exam: ____

Office Address: Title (Must Circle One): **MD** **DO** **NP** **PA** **APN**

COMMENTS:

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OFFICE ADDRESS:

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OFFICE STAMP

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