



Statement of Health

(To be completed by the Healthcare Provider)

I have examined the patient and determined that this person is in good physical and mental health, has no signs or symptoms of communicable diseases, and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

Signature and title of Provider

Date of Examination

Printed Name of Provider

Office / Clinic Address:

(PLEASE PRINT)

Clinic: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Office Telephone Number: _____ Office Fax: _____

Authorization for Medical Release

(To be completed by the employee)

I, _____, do hereby authorize my physician, Dr.

_____ to release my recent medical examination to Signature Healthcare, which is relevant to my employment.

Signature

Date