

**PHYSICIAN'S STATEMENT**

*Employee/Applicant*

Name: \_\_\_\_\_

Last Four Social Security Number: \_\_\_\_\_

**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): \_\_\_\_\_

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

Physician Signature: \_\_\_\_\_

Office Phone Number: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Office Stamp

Office Address:  
\_\_\_\_\_  
\_\_\_\_\_