PHYSICIAN'S STATEMENT

Employee/Applicant

Name: _____

DOB: _____

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): _____

Signature: _____

Office Phone Number: _____

Date of Exam: _____

Office Stamp (if available)

Office Address:

_____

_____