



Employee Health Statement

I have examined _____ . To the best of my knowledge she/he is in good physical and mental health, free of any communicable disease, is able to function in her/his profession without any limitations and physically able to provide services to individuals with compromised health.

Patient's Date of Birth ___ / ___ / _____

Patient's SS# _____ - _____ - _____

Physician's or representative's Name: _____

Physician's or representative's Signature: _____

Date of Examination: ___ / ___ / _____

Facility Stamp

Please print and fax this completed form to our HR Department at 1-866-655-4347