PHYSICAL STATEMENT

_________________________________ _________________________

Last Name First Name

I authorize _________________________________ to release any information acquired during my medical
PHYSICIAN NAME

examination to FOCUS CARE. I also authorize FOCUS CARE to release any information on this statement, relevant to employment, to any of its client facilities.

____

Employee signature date

I have examined the individual named above 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 in his/her profession at full capacity.

____

Provider signature date

____

Provider printed name

____

Phone number