



Health Statement / Physical

Name of employee: _____ Last 4 of Soc Sec# _____

Title/Occupation: _____

Physicians Statement

I have examined the above named individual and find them to be in good health, able to perform their essential job functions, and find them free of communicable diseases.

Physician Signature

Date

Clinic Name / Location

****Please add your location stamp to this form—thank you****