Physician Statement

Notice of Importance:

Our medical facilities require a physician's statement of good health. This form must be filled out completely with the appropriate physician signature and information included. We must receive this completed statement before you begin employment, however do not delay in sending your completed application while getting this form completed.

We will accept an alternate physician statement, but only if all the following information is included. Please remember to attach all copies of test results.

Employee Name: ______________________________

Date of Examination: ______________________________

I hereby authorize the undersigned physician to release any medical information relevant to employment to Certified Home Nursing Solutions LLC.

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Employee Signature Date

I certify that I have performed a physical examination on the above mentioned individual and I further certify that this patient is in good physical and mental health, and is not suffering from any illness or physical or mental disability which would restrict him/her from providing services as a Registered Nurse, Licensed Practical Nurse, Home Health Aide or Certified Nurse's Assistant.

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Physician's Name Date

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Physician's Signature

Physician Office Information or Stamp: