Premier Healthcare Professionals

PHYSICIAN'S STATEMENT FORM

I (*Employee*), _____, do hereby authorize (*Physician*) _____ to release to Premier Healthcare Professionals and any of its client hospitals or, institutions any information acquired in my recent medical examination which is relevant to my employment.

Signature: _____ Date: _____

PHYSICIANS STATEMENT

I have examined the above named individual, and to the best of my knowledge, he/she is in good physical and mental health, free of communicable diseases and is able to function in his/her profession in full capacity.

Physician: _____ Date: _____

Printed Name: _____ Date of Physical: _____

Please include the following:

TB Skin Test Date: _____ Results: _____

CXR
(If TB Test Positive) Date: _____ Results: _____

MMR Immunization Date: _____

Rubella Titer Date: _____ Results: _____ Immunity Present? Y N

Rubeola Titer Date: _____ Results: _____ Immunity Present? Y N

Varicella Titer Date: _____ Results: _____ Immunity Present? Y N

History of Disease Date: _____

Immunization Date: _____

Comments: _____

_____

_____

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