PHP GROUP

PHYSICAL EXAM

(To be completed by physician, NP or PA)

Name: _____

Date of Physical Exam: _____

Additional Comments:

_____

_____

_____

_____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to perform the core functions of the position without restrictions.

Signature: _____

Title of person signing physical_____

Name: _____ License #: _____
(please print)

Address: _____

City: _____ State: _____ Zip: _____