# Physician's Statement Form

Date of Physical: _____

I have examined _____, and to the best of my knowledge, he/she is free of communicable diseases and is fit to work without restrictions or limitations.

_____ _____
Signature of Physician/Physician's Assistant/Nurse Practitioner (Circle One) Date

_____
Printed Name of Physician/Physician's Assistant/Nurse Practitioner (Circle One)

_____
Practice/Clinic Name

_____
Address Phone Number