For Office Use Only
Date Received:_____,20___
Reviewed by:

Physicians Statement

I have obtained and reviewed a current history of the individual named below, and to the best of my knowledge, s/he is in good physical and mental health, has no physical limitations or communicable diseases, and is able to function in her/his professional discipline and specialty on a full-time basis and at full capacity without any accommodations.

Patient Printed Name: _____ **D.O.B:** _____

Physician's Signature: _____

Printed Name: _____

Office Address: _____

City, State, Zip Code: _____ _____ _____

Office Phone Number: _____ **Date:** _____