

ection A Medical Release Autho	orization	(To Be Completed by the Employ
,EMPLOYEE NAME	, do hereby authoriz	e
Employee Name		Physician Name
o release any information acquired d	uring my medical exam	nination to MedStaff, Inc. I
also authorize MedStaff, Inc. to relea	ase any information or	this statement, relevant to
employment, to any of its client facil	ities.	
Employee S	GIGNATURE	Date
ection B Statement of Physical	Health (To	BE COMPLETED BY THE HEALTHCARE PROVI
sction b Statement of Physical	<u> </u>	
Statement of Physical	·	
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I have examined	and determin	ed that this person is in good healt
·	and determin	ed that this person is in good healt
I have examined EMPLOYEE NAME has no signs or symptoms of commu	and determin	ed that this person is in good healt
I have examined EMPLOYEE NAME has no signs or symptoms of commu	and determin nicable disease, and is a MD, DO	ed that this person is in good healtable to perform the functions of the
I have examined	and determin nicable disease, and is a MD, DO	ed that this person is in good healtable to perform the functions of the D, NP, PA
I have examined	and determin nicable disease, and is a MD, DO	ed that this person is in good healtable to perform the functions of the D, NP, PA
I have examined  EMPLOYEE NAME has no signs or symptoms of commu position without restriction.  SIGNATURE  PRINTED NAME (PLEASE PRINT)	and determing nicable disease, and is a second many disease.  MD, DO TITLE OF PROVE	ed that this person is in good healtable to perform the functions of the D, NP, PA
I have examined  EMPLOYEE NAME  has no signs or symptoms of commu  position without restriction.  SIGNATURE  PRINTED NAME (PLEASE PRINT)  OFFICE ADDRESS: (PLEASE PRINT)	and determin nicable disease, and is a MD, DO TITLE OF PROV	ed that this person is in good healtable to perform the functions of the D, NP, PA  VIDER (PLEASE CIRCLE)  M DATE
I have examined  EMPLOYEE NAME  has no signs or symptoms of commu  position without restriction.  SIGNATURE  PRINTED NAME (PLEASE PRINT)  OFFICE ADDRESS: (PLEASE PRINT)  Street:	and determing nicable disease, and is a second many many many many many many many many	ed that this person is in good healt able to perform the functions of the D, NP, PA  O, NP, PA  //DER (Please Circle)  M DATE  Zip: