

Section A Medical Release Authorization (To Be Completed By The Employee)

I, _____, do hereby authorize _____

EMPLOYEE NAME

PHYSICIAN NAME

to release any information acquired during my medical examination to MedStaff, Inc. I also authorize MedStaff, Inc. to release any information on this statement, relevant to employment, to any of its client facilities.

EMPLOYEE SIGNATURE

DATE

Section B Statement of Physical Health (To Be Completed By The Healthcare Provider)

I have examined _____ and determined that this person is in good health, has no signs or symptoms of communicable disease, and is able to perform the functions of the position without restriction.

EMPLOYEE NAME

_____ MD, DO, NP, PA

SIGNATURE

TITLE OF PROVIDER (PLEASE CIRCLE)

PRINTED NAME (PLEASE PRINT)

EXAM DATE

OFFICE ADDRESS: (PLEASE PRINT)

Street: _____

City: _____ State: _____ Zip: _____

Office Telephone Number: _____ Office Fax: _____