



STATEMENT OF GOOD HEALTH

After examination _____ has been found to be physically and mentally able to perform the duties of _____, and is free of communicable disease. He/she was also found to be in good health and able to provide services to individuals with compromised health.

Date of Physical Exam: _____

Physician's Signature: _____

Only an M.D., D.O., ARNP or a Physician's Assistant can certify clearance of communicable diseases

Print Name of Physician: _____

Physician's office Telephone & Address (Must Be Stamped by the Physician's Office)

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