9700 Lakeshore Drive E, Suite C
Inianapolis, IN 46280
Phone: 317-862-8141
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EMPLOYEE HEALTH STATEMENT

Date: _____ Patients Name: Position:

_____ _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Blood Pressure: _____ Weight: _____

Pulse: _____ Height: _____

Respiration: _____ Vision: _____

Temperature: _____ Lungs: _____

Allergies:

_____

Medications:

_____

Special Considerations:

_____

Physician's Statement: I have examined the above patient and have found this individual physically and mentally capable of performing the necessary duties of a healthcare provider, having no evidence upon physical exam of any communicable diseases.

_____ _____

Physician's Signature Date

_____

Physician's Printed Name

_____

Address, City, State, Zip

_____

Phone Number