Therapeutic Resources

PHYSICAL STATEMENT & HEALTH STATUS

I,_____ , do hereby authorize_____

CLIENT NAME *PHYSICIAN NAME*

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

_____***CLIENT SIGNATURE*** _____ ***DATE***

Does this client have any latex allergies: Yes No

I have examined the patient and determined that this person is in good physical and mental health, has no signs or symptoms of communicable diseases, and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

MD, DO, NP, PA, CNM

_____***SIGNATURE*** ***TITLE OF PROVIDER*** *(PLEASE CIRCLE)*

_____***PRINTED NAME*** _____ ***LICENSE NUMBER***_____***DATE***

OFFICE ADDRESS:

(PLEASE PRINT)

Street: _____

*City*_____ *State*_____ *Zip*_____

Office Telephone Number: _____ *Office Fax:*_____