Health Statement

Please fax completed form to FlexRN at: 1-888-482-0048

Authorization and Release

I authorize FlexRN to procure a general statement of the condition of my health and ability to perform clinical services and to obtain my vaccination/titer history. I authorize my Physician to release such information and release him/her from any liability arising from such disclosure.

_____ _____

Employee/Patient Signature **Date**

Employee/Patient Name: _____ Date of Birth: _____

Physicians Statement (to be completed by Physician/NP/PA)

To the best of my knowledge, this person is in good physical health, free from back injury, free from communicable disease, able to perform routine clinical duties and be screened for fit testing. Employee is free from work restrictions.

I have examined the above-mentioned person within the last 12 months.

Date of Last Examination: _____/_____/_____

Additional Comments:

_____
_____

Physician Name (please print):_____
Physician's Address: _____
City: _____ **State:** _____ **Zip:**_____

Office Phone Number: _____

******Physician's (MD/NP/PA) Signature:*** _____

Office Stamp

2124 Jefferson Davis Highway, Suite 301, Stafford, VA, 22554 PHONE: 866-781-0726 FAX: 888-482-0048