TRIAGE

Health Statement / Physical

Patient's Name: Name

Date of Service: _____

DOB: _____

Title/Occupation: Title

Physician's Statement

I have examined the individual named above and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and able to function in his/her profession at full capacity without limitation or restrictions. By signing below I certify that the above information is valid and if accommodations or restrictions are required, they will be documented above.

_____
Physician Name
(Please indicate credentials i.e. MD, DO, PA, NP, etc.)

_____
Signature

_____
Date

Please include location stamp or write the clinic name and address here.

*****Please email form to compliance@triagestaff.com or fax to 800-701-9855 when complete*****

Questions? Contact our compliance team at 800-259-9897 ext. 128 or use the email address above.