ECM STAFFING
EMERALD CITY MEDICAL STAFFING

Physical Exam/Statement of Health

Employee Name: _____

Employee Date of Birth: _____-_____-_____

Physician Name or Practice, Address and Phone Number **(MUST BE STAMPED):**

_____

_____

_____

Physical Examination Date: _____

_____ (Employee) is in overall good health and has no work restrictions. You have found him/her fit to work and to be free of communicable diseases which could be a potential risk to patient's or may interfere with the performance of the employee's duties as a healthcare worker.

Provider's Name (PRINT): _____

Provider's Signature: _____ Date: _____