

PHYSICIAN STATEMENT

I hereby specifically authorize my physician to release medical documentation relevant to any work related accommodations to the company.

Print Employee Name

Signature of Employee

Employee ID #

Date

A. Physician Statement of Ability to Work: (Section B must be signed)

I have examined and obtained a current history on the individual named above; and to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical limitations, and is able to function in his/her professional discipline and specialty on a full-time basis at full capacity without any accommodations **(including for allergies)** or with the accommodations listed below:

B. Physician Information

Printed Name

MD PA DO NP Other: _____

(Explain)

Signature

Phone Number

Date