PHYSICIAN'S STATEMENT

Name: _____ Social Security #: _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease, and able to function without physical limitations as a healthcare professional.

Immunizations Status

Document date of vaccine/titer given and results. (Please attach all titer/vaccine results.)

Type	Vaccination	Titer	Date	Results
Rubella				
MMR				
Rubeola				
Mumps				
Varicella				

Type	Date Given	Date Read	Results
PPD/TB or CXR (if PPD positive)			

Type	Date	Signature
Hepatitis B Titer		_____Immune _____Non-Immune
Hepatitis B Vaccine-1		
Hepatitis B Vaccine-2		
Hepatitis B Vaccine-3		

Physician Signature: _____ Date of Exam: _____

Physician Name: _____License Number: _____

Address: _____City: _____

State: _____ Zip: _____ Phone: _____

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