Physician's Statement

I have examined____, and to the best of my knowledge, she/he is in good physical and mental health, free of any communicable disease, and is able to function in her/his profession at full capacity.

Physician Signature: ____
Date: ____

If Requested:

TESTING AND LAB RESULTS

	Date	Result
PPD/TB Skin Test…………………………………	__________	__________
Or CXR (for positive PPD/TB only………………	__________	__________
Rubella Titre………………………………………	__________	__________
Rubeolla Titre…………………………………...	__________	__________
Varicella Titre…………………………………...	__________	__________
MMR Vaccine……………………………………..	__________	__________

Optional:

Hepatitis B Titre……………………………………	__________	__________

Other information/notes:

PLEASE ATTACH ALL LAB RESULTS

Physician Signature: ____
Date: ____