AN INGENOVIS HEALTH COMPANY

Employee/Applicant

Name: _____

Statement of Health

To be completed by Provider

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 is able to function in his/her profession at full capacity.

By signing below, I certify that the above statement is true.

Name (Printed): _____

Title (Must Circle One): **MD DO NP PA APN APRN**

Provider Signature: _____

Office Phone Number: _____

Date of Exam: _____

Office Stamp

Office Address:

_____

_____