



GIFTED CLINICIANS. COMPASSIONATE CARE.

### Medical Release and Physician Statement

#### MEDICAL RELEASE AUTHORIZATION

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_,

Applicant's Name Physician or Client

to release to Gifted Healthcare any information acquired in my medical examination that is relative to my employment. I also authorize Gifted Healthcare to release any information that is relative to employment at any of their client facilities.

\_\_\_\_\_

Applicant Signature Date

#### PHYSICIAN STATEMENT

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

\_\_\_\_\_

*Physician, Nurse Practitioner, or Physician's Assistant*

\_\_\_\_\_

Printed Name License Number

Date of Physical Exam: \_\_\_\_\_ Title \_\_\_\_\_

Office Phone Number: (\_\_\_\_\_) \_\_\_\_\_