PROLINK HEALTHCARE

Physician Statement of Health

Candidate Name: _____

Candidate Date of Birth: _____

Candidate Signature: _____

The above-named patient has been examined by me and found to be in acceptable physical and mental health, free from communicable diseases, and able to function at full capacity.

Signature_____

Date_____

Print Name_____

Title _____

Office Address: _____

_____

License Number _____

Phone_____

Fax _____