Physician's Statement

I,____________________________ do hereby authorize____________________________

Applicant Name (Print Please) **Physician Name (Print Please)**

to release any information acquired during my medical examination to Southern Healthcare. I also authorize Southern Healthcare to release any information on this statement, relevant to employment, to any of its clients or facilities.

__________________________________ ____________________________

Applicant Signature **Date**

The above named individual is found to be in good physical and mental health, free from communicable diseases, and able to function and perform all job duties as a healthcare professional, without any limitations, in his/her profession at full capacity.

_________________________________ ___________________________

Physician Signature **Date**

Physician Address:

Clinic Name________________________

Street______________________________

City_____________________

State_______ Zip____________

Please return this form to: Southern Healthcare Agency, Inc.
P.O. Box 320999
Flowood, MS 39232-0999

Fax: 601-933-0067
Phone: 601-933-0037
Email: recruiters@southernhealthcare.com