PHYSICIAN'S STATEMENT

This Physician's Statement must be completed by an MD, Physicians Assistant or Nurse Practitioner. Please have them complete the area below based a simple pre employment physical and include a stamp from the facility with office name and address.

Patient Full Name: _____

Date of Birth: _____

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

Physician Signature: _____ Date of Exam: _____

License Number: _____ Name of Physician: _____

Physician Address: _____

City: _____ State: _____ Zip Code: _____

Facility Stamp:

PPR Talent Management Group

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