PPR Talent
Management
Group

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

333 First Street North, Suite 200 Jacksonville Beach, FL 32250

Phone 866-387-5038 Fax 888-774-5039