

**Physicians Statement (to be completed by Physician/NP/PA)**

**Employee/Patient Name: Date of Birth:**

To the best of my knowledge, the above patient is in good physical health, free from back injury, free from communicable disease, able to perform routine clinical duties. Patient/Employee is free from any work restrictions.

I have examined the above-mentioned person within the last 12 months.

Date of Last Examination \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_.

Additional Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name (please print):**

**Physician’s Address:**

**City:** **State:** **Zip:**

**Office Phone Number:**

***\*\*\*Physician’s (MD/NP/PA) Signature:***

Office Stamp

**9270 Junction Rd Suite A, Frankenmuth, MI 48734 PHONE: 989-607-9329 FAX: 877-652-5053**