



CORPORATE OFFICE
2605 WEST ATLANTIC AVENUE. DELRAY BEACH, FL 33445
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LOCATIONS: **BROWARD** NR30211390 **DELRAY** NR30210978 **FORT MYERS** NR30211293 **MIAMI** NR30211382 **NAPLES** NR30211226 **ORLANDO** NR30211316

PHYSICIANS REPORT

Name: _____ Date: _____

Address: _____

I _____ authorize the release of my medical information for work related purposes.

Contractor's Signature

Date of Physical Exam: _____

Physician's signature _____

Only an M.D., D.O., ARNP or a Physician's Assistant can certify clearance of communicable diseases

I certify that the above patient is free of communicable disease

Name of Physician: _____

Address: _____

Telephone Number: _____ Fax: _____

License Number: _____ State: _____ Date: _____

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