



7922 E. Edgewood Ave.  
Indianapolis, IN 46239  
Phone: 317-862-8141  
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### EMPLOYEE HEALTH STATEMENT

Date: \_\_\_\_\_ Patients Name: \_\_\_\_\_ Position: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Weight: \_\_\_\_\_

Pulse: \_\_\_\_\_

Height: \_\_\_\_\_

Respiration: \_\_\_\_\_

Vision: \_\_\_\_\_

Temperature: \_\_\_\_\_

Lungs: \_\_\_\_\_

Allergies:

\_\_\_\_\_

Medications:

\_\_\_\_\_

Special Considerations:

\_\_\_\_\_

**Physician's Statement:** I have examined the above patient and have found this individual physically capable of performing the necessary duties of a healthcare provider, having no evidence upon physical exam of any communicable diseases.

\_\_\_\_\_  
Physician's Signature Date

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Address, City, State, Zip

\_\_\_\_\_  
Phone Number