



**Annual Physical/Health Statement**

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*(To be completed by a Physician, Nurse Practitioner or Physician Assistant. All dates must include day-month-year)*

**Name of Patient** (Please Print): \_\_\_\_\_

**Last 4 digits SSN:** \_\_\_\_\_ **Date of Physical Exam** \_\_\_\_\_

The above mentioned person has been examined by me and to the best of my knowledge, he/she is in good physical and mental health, free of any back problems, free from any communicable diseases and able to function in his/her profession at full capacity with no limitations.

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*Signature of Physician, Nurse Practitioner or Physician Assistant*

*Date*

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*Please print Name*

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**OFFICE STAMP** with address, phone and fax (**REQUIRED**)

**\* This document is subject to verification.**