|  |  |
| --- | --- |
| Healthcare Provider [Street address]  [City, ST ZIP Code] | [Contact information for Privacy Official] |
| Health CertificatePATIENT INFORMATION |  |
|  | Date |
|  |  |
| Name (Last, first, middle initial) | Social Security # or Patient ID |
|  |  |
| Street address, City, ST, ZIP Code | Date of Birth |
|  |  |
| Primary phone number | Other phone number | Email address |

**I have examined the above-mentioned person/patient and certify that he/she is**

* **Free from diseases [INSERT DETAILS]**
* Appears to be in satisfactory physical and mental health condition, capable of doing physical household/office tasks, supervise and give care to adults.

In addition to a general physical health examination, the following tests have been done:

|  |  |  |
| --- | --- | --- |
| * Tuberculin Test | Date: | Result: |
| * Chest X-ray | Date: | Result: |
| * Other | Date: | Result: |
| * Other | Date: | Result: |
| **Remarks**: | | |
|  | | |
|  | | |
|  | | |

Please list [Company Name] staff members that were contacted regarding this matter:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name |  | Date |
|  |  |  |
| Name |  | Date |
|  |  |  |
| Signature |  | Date |
| **Signature of Examining Physician/Nurse Practitioner** |  |  |
|  |  | Date of Examination |
| Privacy Official signature |  | Date |

Attach additional documentation, if applicable.