



**PHYSICAL STATEMENT
& HEALTH STATUS**

Phone: 310-372-0560/Fax: 877-707-5576

Section A MEDICAL RELEASE AUTHORIZATION (To be completed by Nurse)

I, _____, do authorize _____
Nurse Name

to release any information acquired during my medical examination to Procel Temporary Services Inc. I also authorize PROCEL to release any information on this statement, relevant to employment, to any of its client facilities.

Client (Nurse) Signature _____
Date

Section B STATEMENT OF PHYSICAL HEALTH (To be completed by physician)

I have examined the patient and determined that this person is in good physical health, free of communicable diseases, and able to perform the essential functions of his or her profession:

- With out limitations
- With the following limitations, with or with out accommodations:

Vision Screening (SNELLEN) Test Results: _____ / _____ (If Test Conducted – Not Required)

Physician Signature _____ _____
License Number _____
Date

Physician Name (Please Print)

Physician Stamp: (MUST BE STAMPED. DO NOT HAND PRINT)

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