MEDICAL RELEASE AUTHORIZATION

If your doctor has records for any of the below procedures that you cannot provide separate documentation for, please complete this section and bring this form to your doctor to complete the appropriate areas below on your behalf.

I, ____, do hereby authorize my physician or physician's office

____ to release to Core Medical Group any information acquired in my recent medical examination which is relevant to my employment.

____ ____________________

Signature Date

PHYSICIAN'S STATEMENT

Please Note: You do not need to have this form signed and completed if you have separate documentation for any of the below procedures that may be required for your assignment.

Date of Physical ____________________

I have examined ________________________________, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity.

____ ____________________

Signature of Physician/Physician's Assistant/Nurse Practitioner (Circle One) Date

____ ____________________

Printed Name of Physician/Physician's Assistant/Nurse Practitioner (Circle One) Practice/Clinic Name

____ ____________________

Address Phone Number

DID THE EXAM INCLUDE ANY OF THE FOLLOWING:

TB Skin Test Date Planted: ______________ Date Read: ______________ Results: ______________

Date Planted: ______________ Date Read: ______________ Results: ______________

Chest XRay Date: ______________ Results: ______________ Positive Hx Date: ______________

Hepatitis B Vaccinations Date #1: ______________ Date # 2: ______________ Date #3: ______________

Tdap/TD Vaccination (Circle One) Date: ______________

Mask Fit Test Date: ______________ Type/: Size ______________

MMR Vaccination Date #1:__________ Date #2: __________

Varicella Vaccination Date #1: __________ Date #2: __________

Rubella Titer Date: __________ Results: __________

Rubeola Titer Date: __________ Results: __________

Mumps Titer Date: __________ Results: __________

Varicella Titer Date: __________ Results: __________

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