

SINTE GLESKA UNIVERSITY NURSING PROGRAM

PHYSICIAN'S STATEMENT

Employee/Applicant

Name: _____

D.O.B: _____

Statement of Health

To be completed by Physician

I have examined the individual named above 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.

By signing below, I certify that the above information is true.

Name (printed): _____

Title (Must circle one): MD DO NP PA APN APRN

Physician Signature: _____

Office Phone Number: _____

Date of Exam: _____

Office Address: _____

Office Stamp

