Approved
HOME HEALTH

Physician's Health and Physical Fitness Statement

_____Pre-Employment

Name:_____ SSN#:_____

Address:_____

Position applied for:_____LPN_____HHA/C.N.A. _____Homemaker/companion

I hereby certify that the above patient is capable of performing normal functions and duties of the above position, and is free from any communicable/infectious diseases.

Limitations:_____

Physician's Printed Name:_____

License Number_____State_____

_____ _____
Physician's Signature **Date**

In accordance with Privacy Rule 45 CFR 164.504, 164.532 for business associates, be assured information obtained will be appropriately safeguarded and the release of information held to a minimum reasonably needed for the purpose of disclosure.

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