

Section A Medical Release Authorization (To Be Completed By The Traveler)

I, _____, do hereby authorize _____

CLIENT NAME

PHYSICIAN NAME

to release any information acquired during my medical examination to CRU 48. I also authorize CRU 48 to release any information on this statement, relevant to employment, to any of its client facilities.

CLIENT SIGNATURE

DATE

Section B Statement of Physical Health (To Be Completed By The Healthcare Provider)

Does this client have any latex allergies: Yes No

I have examined the patient and determined that this person is in good physical and mental health, has no signs or symptoms of communicable diseases, and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

_____ MD, DO, NP, PA, CNM _____

SIGNATURE

TITLE OF PROVIDER (PLEASE CIRCLE)

PRINTED NAME (PLEASE PRINT)

LICENSE NUMBER

EXAM DATE

OFFICE ADDRESS: (PLEASE PRINT)

Street: _____

City: _____ State: _____ Zip: _____

Office Telephone Number: _____ Office Fax: _____