ANCHOR MEDICAL STAFFING

19220 Lorain Road
Fairview Park, Ohio 44126

PHYSICIAN STATEMENT

I hereby specifically authorize my physician to release medical documentation relevant to any work related accommodations to the company.

Print Employee Name	**Signature of Employee**
Employee ID #	**Date**

A. Physician Statement of Ability to Work: (Section B must be signed)

I have examined and obtained a current history on the individual named above; and to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical limitations, and is able to function in his/her professional discipline and specialty on a full-time basis at full capacity without any accommodations **(including for allergies)** or with the accommodations listed below:

B. Physician Information (if you are not a MD, PA, DO or NP please refer this candidate to another Healthcare Professional)

Printed Name ☐ MD ☐ PA ☐ DO ☐ NP

Signature	**Phone Number**	**Date**
Facility Address	**City**	**State**