PHYSICIAN'S STATEMENT

I hereby authorize TLC Nurse Solutions to use or disclose this information to its clients or facilities which may be relevant in evaluating my qualifications for opportunities

Signature Date

I certify that _____ is in good physical and mental health, free of any communicable diseases, and is able to physically perform nursing services without restrictions.

_____
Patient's Date of Birth

_____ _____
Physicians Signature Date of Medical Examination

_____ _____
Physician's License Number Physician's Name