



PHYSICIAN'S STATEMENT

I authorize TLC Nurse Solutions to use or disclose the information below to its clients or facilities, as may be relevant in evaluating my qualifications for nursing opportunities.

Nurse's Name: _____

Date of Birth: _____

I certify that the individual named above is in good physical and mental health, free from any communicable diseases, and able to perform nursing services without restrictions.

Physician's Signature: _____

Date of Examination: _____

Physician's Name: _____

Physician's License Number: _____