Applicant's Name (print): _____

BOCA HOME HEALTH

PHYSICAL EXAMINATION FORM

PHYSICIAN STATEMENT:

In my opinion, _____, is physically able to perform all work related duties, and is free of signs and symptoms of communicable disease, including TB.

_____ _____

Physician Signature Date

_____

Physician's Name (printed)

_____

Physician's Stamp

_____

Physician's Street Address

_____

City/State/Zip-code

Health Care professionals licensed under Chapter 458 or 459, F.S., a physician's assistant, or an advanced registered nurse practitioner (ARNP) or a registered licensed Chapter 458, or 459 under the supervision of a licensed physician. Physicals administered by a Chiropractor, Osteopath, Podiatrist, Dentist, optometrist, cannot be accepted as per the State of Florida Statutes. (See Florida Statute 459 & 450).