



PHYSICAL STATEMENT & HEALTH STATUS

SECTION A MEDICAL RELEASE AUTHORIZATION (TO BE COMPLETED BY THE TRAVELER)

I, CLIENT NAME, do hereby authorize PHYSICIAN NAME

to release any information acquired during my medical examination to Cross Country TravCorps. I also authorize Cross Country TravCorps 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.

SIGNATURE TITLE OF PROVIDER (PLEASE CIRCLE)

PRINTED NAME (PLEASE PRINT) LICENSE NUMBER DATE

OFFICE ADDRESS: (PLEASE PRINT)

Street:

City: State: Zip:

Office Telephone Number: Office Fax: