Section A Medical Release Authorization (To Be Completed by the Employee)

I, _____, do hereby authorize _____
Employee Name 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.

_____ _____
Employee Signature Date

Section B Statement of Physical Health (To Be Completed by the Healthcare Provider)

I have examined _____ and determined that this person is in good health, has no signs or symptoms of communicable disease, and is able to perform the functions of the position without restriction.
Employee Name

_____ MD, DO, NP, PA
Signature Title of Provider (Please Circle)

_____ _____
Printed Name (Please Print) Exam Date

OFFICE ADDRESS: (Please Print)

Street: _____

City: _____State:_____ Zip: _____

Office Telephone Number: _____ Office Fax: _____