# Annual Health Statement

**Patient Name**: _____

**The above patient has been examined by me and has been found to be in good mental and physical health, free of communicable disease, and able to function in the healthcare profession without any physical limitations.**

**Date of Exam**: _____

**PROVIDER'S PRINTED NAME:** _____

**TITLE OF PROVIDER (PLEASE CIRCLE ONE): MD, DO, NP, PA**

**PROVIDERS SIGNATURE:** _____

**License Number:** _____

**Office Phone Number:** _____

I authorize my physician to release my health records to Registry Network. I realize that Registry Network, Inc. may release my health records to client facilities as a condition of placement.

**Employee Signature: _____** Date: _____

Form Updated 5-22-24