ATTACHMENT I: Medical Clearance Form for Contract Nursing Service Provider Personnel

NC DHHS, Division of State Operated Healthcare Facilities

Medical Clearance Form for Contract Nursing Service Provider Personnel

Name: _____

I have examined the above- named individual, and to the best of my knowledge, he/she is in good physical and mental health, free from communicable diseases, and able to perform all job duties at full capacity, without restrictions.

Physician Signature: _____

Physician Name (printed)_____

Date of Exam: _____

Physician License Number: _____

Facility/Clinic Name: _____

Address: _____

Telephone Number: _____