



To: _____

Please fax this completed form to 847-775-7446.

EMPLOYEE HEALTH INFORMATION RELEASE

I give my permission for Dr. _____ to release any information concerning my physical condition that Assured Healthcare requests.

Date: _____ Signed: _____

Witness: _____

Physician: Please fill in the following information:

1. Date of last physical examination _____
2. Date of last TB skin test or chest x-ray _____
3. Is person free of communicable disease? YES NO
4. Is person physically and emotionally able to work? YES NO

Date: _____ Signature: _____