910 South Main Street
West Bend, WI 53095
Phone: 262-677-2180
Fax: 262-677-3822
staff@asi-wi.com / www.asi-wi.com

Physician Statement

Name of Employee: _____

I have examined the above named individual and found him/her to be free from health conditions and free of communicable diseases which would be of potential risk to patients or which might interfere with the performance of his/her duties as a healthcare worker.

Signature of Physician: _____ Date: _____

Print name of Physician: _____

Address of Physician: _____

_____

Phone Number of Physician: _____

This form must be faxed to us directly from the office or clinic of your physician: 262-677-3822