STAFF HEALTH REPORT

Physician's Statement

INSTRUCTIONS: Please provide a copy of this form to each employee to be given to his/her examining physician. The top portion of the form should be completed by the employee; the bottom portion must be completed and signed by the physician, physician's assistant, or licensed nurse practitioner. The signature of an R.N. or L.P.N. is NOT acceptable. Staff must have this form completed and submit it on an ANNUAL basis.
Name of Religious Institution
Name of Staff Member
This statement is signed in compliance with the Code of Virginia, Section 63.2-1716. I certify that
Physician/Nurse Practitioner's Signature: Physician/Nurse Practitioner's Printed Name: Date (Month/Day/Year)
Address: Telephone Number

032-05-0977-01-eng (06/08)