PHYSICIAN'S STATEMENT

Date:_____

Applicant's Name: _____
Last First MI

Address: _____
Street City State Zip

I, _____, do hereby certify that I have examined the above named patient within the past year and he/she is free of communicable diseases, including Tuberculosis, and is in good mental and physical health, and is able to care for the elderly and/or infirm persons.

Physician's Signature _____

Physician's Name (Please Print or Type): _____

Address: _____
Street City State Zip

Telephone: ( ) _____

Please Note: This form must be completed by your physician and return with your completed application.