Worldwide Travel Staffing

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Physical Statement for Facilities in Kansas

Employee Name:_____ **Date of Birth:** _____

Medical Practitioner's Name (MD, DO, PA, or ARNP): _____
(Circle One) *(Please Print)*

The above-named individual is:

In good physical and mental Health.	☐ Yes ☐ No
Able to function in their profession at full capacity, absent any restrictions.	☐ Yes ☐ No
Free of any communicable diseases.	☐ Yes ☐ No

Medical Practitioner's Signature: _____ **Date:** _____

The Medical Practitioner must stamp in the box below: