CLINICAL STAFF SUPPORT, INC NURSING GROUP, INC

Physician Statement

Employee/Candidate Information

Employee Name: _____Date:_____

Employee Authorizing Signature:_____

Digital or Written Signature

I hereby specifically authorize my physician/healthcare professional to release medical documentation relevant to any work related accommodations to the company.

A. Provider Statement of Ability to Work: (Section B must be signed)
I have examined and obtained a current history on the individual named above: and to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical or mental limitations, and is able to function in his/her professional discipline and specialty on a full time basis at full capacity without any accommodations (including allergies) or with the accommodations listed below:

B. Physician/Healthcare Provider Professional Information. (If you are not an MD, PA, NP or DO please refer this candidate to another Healthcare Professional)

Printed Name: _____ _____MD _____PA _____DO _____NP

Signature: _____ Date: _____

Submission Instructions

Documentation may be submitted using any of the following 3 ways:
1. Fax: 800-331-1531
2. Email Scanned documentation: staffing@nursinggroup.com.
3. Mail: Clinical Staff Support, Inc P.O. Box 446 Round Rock, Texas 78680-0446

If any questions please contact Clinical Staff Support, Inc and or Nursing Group, Inc at 800-331-1531