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 to release medical documentation relevant to any work related accommodations to the company.

A. Physician 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 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 for 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)

_____ MD ☐ PA ☐ DO ☐ NP ☐

Printed Name

_____ _____

Signature Date

_____

Phone Number

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