



Health Clearance Form

Patient Name: _____

Date of Physical Examination: _____

I attest that I have examined the above-named patient and find he/she to be in good physical health and free of communicable diseases including, but not limited to, Amebiasis, E. Coli, Shigellosis, Typhoid fever/paratyphoid fever, Hepatitis A and Persistent diarrhea.

He/She is free to work without any restrictions in the role/job description accepted.

Physician/NP/PA Signature: _____

Date: _____

Physician/NP/PA Printed Name: _____

Health Center Name: _____

Address (optional): _____

City, State, Zip: _____

Contact Phone: _____

****Please note: IntelyCare does not cover the cost of physical exams and/or health screenings.****