Name:_____

I hereby authorize Winners Healthcare to use or disclose this information to its client facilities, which may be relevant in evaluating my qualifications for employment opportunities and related activities.

Signature:_____ Date:_____

Annual Health Statement

The above individual has been examined by me and found to be in good health without evidence of communicable disease. They are able to perform their job duties at full capacity with no limitations and have no medical condition that would be aggravated or interfere with the use of respiratory protection.

Physician or Nurse Practitioner:

Name:_____ Phone Number:_____

Address:_____

Signature:_____ Date:_____

THANK YOU FOR YOUR COOPERATION. PLEASE FAX THIS FORM BACK TO (708) 929-6660.

NO COVER SHEET IS REQUIRED.