



Physical Exam

Please fax to: 209-391-1660 or email a copy to clinicalcredentialing@gqrgm.com

Employee Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Social Security Number: _____

Fit For Duty Statement

The above-named patient has been examined by me and found to be in good physical and mental health, and able to function at full capacity.

Physician's Name (please print): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

MD/DO, PA or NP Signature: _____ Date: _____

Additional Comments: _____
