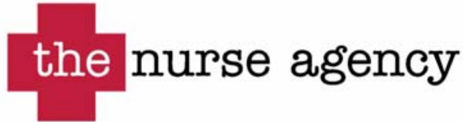

Comprehensive Health Statement

Name of Patient (Please Print): ______________________________ 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: _________________________

10829 S. Western Avenue, Suite B, Chicago, IL 60643 Phone: (773) 779-8200 Fax: (773) 779-8866