



STAFFING

The right connection. Guaranteed.

MEDICAL RELEASE AUTHORIZATION

**This Medical Release Authorization must be received prior to beginning your assignment.
This authorization is valid for one year.**

I, _____ do hereby authorize _____, to release to
Employee Name Physician Name
NC STAFFING and any of its client hospitals or institutions any information acquired in my recent medical examination which is relevant to my employment.

Employee Signature: _____ Date: _____

PHYSICIAN'S STATEMENT

I have seen and examined the above individual, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity.

Physician Name (Please print): _____ Date of Exam: _____

Physician Signature: _____ Date: _____

Please complete the following:

	Date Performed	Results
TB Skin Test	_____	_____
Chest X-Ray (only if positive PPD)	_____	_____
Rubella Titer	_____	_____
Rubeola Titer	_____	_____
Varicella Titer	_____	_____
MMR Immunization	_____	_____
Hepatitis B Vaccine (1)	_____	_____
Hepatitis B Vaccine (2)	_____	_____
Hepatitis B Vaccine (3)	_____	_____