

# Ambulette Employee Physician Statement

Service Name:

\_\_\_\_\_

Employee Name:

\_\_\_\_\_

Employee Date of Hire: \_\_\_\_\_

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## Physician Statement:

I certify that I have examined and reviewed the medical history of \_\_\_\_\_ on \_\_\_ / \_\_\_ / \_\_\_ and find he / she does not have a medical condition, physical condition, including vision impairment (not corrected), which could interfere with safe driving, passenger assistance, the provision of emergency treatment activity, or could jeopardize the health and welfare of client and/or general public.

\_\_\_\_\_

Signature

MD / DO / CNP / PA

Physician Name: (print)

\_\_\_\_\_

Physician Address:

\_\_\_\_\_

Phone Number:

\_\_\_\_\_