McLaren Medical Group

OFFICE STAMP

PRE-EMPLOYMENT PHYSICAL EXAM – CLEARANCE FORM

Name: ____ Date of Birth: ________________

____ Accepted ____ Declined

☐ Accepted with recommended accommodations: ____
____
____
____
____

☐ Further testing required to evaluate ability or risk: ____________________________________
____
____
____
____

☐ Medical Hold – (waiting for additional data): ____
____
____
____
____

Additional Comments: ____
____
____
____
____

Name of examining provider (print) ________________________ Date/Time of Exam ______________

Address ____ Telephone ____________________

Signature of examining provider ____

Patient Name:

Date of Birth

MM-34603 (8/13)

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