DREAMTEAM HEALTHCARE SOLUTIONS LLC
5150 Candlewood Street, Lakewood, California, 90712
(800) 560-4686 info@dreamteamhs.com

PHYSICIAN'S STATEMENT

Applicant's Name: _____

Date of Birth: _____ Last four of SS#: _____

Statement of Health

I have examined the applicant named above. To the best of my knowledge, he/she is in good physical and mental health, free of any communicable disease. He/she can function in his/her profession at full capacity. By signing below, I certify that the above information is accurate and true.

Name (Print): _____

Title (Circle one): MD DO NP PA APN. APRN

Physician Signature: _____

Office Phone #: _____

Date of examination: _____

Office Address: _____

_____

_____

Office Stamp