HEALTH EVALUATION FORM

Dear Appointment/Reappointment Applicant:

Please forward this form to your personal physician for completion. This is a requirement in the appointment/reappointment process.

Your application will be considered incomplete without this documentation

TO THE PERSONAL PHYSICIAN OF:
I authorize release of the following information as a requirement for appointment/reappointment as an Allied Health Professional.

Sincerely,

Applicant's Signature **Date**

TO BE COMPLETED BY PHYSICIAN (print name):

1. Date of last physical examination:

2. Present health status: ☐ Good ☐ Fair ☐ Poor
   If fair or poor, please state reasons:_____

3. Is this individual currently under your care or, to your knowledge, the care of any other physician for a continuing health problem(s)? ☐Yes ☐ No If yes, please explain and include any limitations and/or prescribed medications:

4. Does this individual have any medical and/or psychiatric problems that may affect or are reasonably likely to affect his/her ability to perform the requested privileges or perform his/her duties as an Allied Health Professional? ☐ Yes ☐ No
   If yes, please explain:

5. Would you recommend that this individual be appointed with clinical privileges as requested from the standpoint that he/she is capable of making appropriate decisions and performing duties as requested? (This recommendation is **not** based on **competence,** but rather physical/mental health.) ☐Yes ☐ No If no, please explain:

Physician's Signature **Date**

Please return to:

Medical Staff Office
Hendrick Medical Center
1900 Pine Street
Abilene, Texas 79601
Phone: 325-670-3465
Fax: 325-670-3458