



**ALLIANCE
SERVICES, INC**

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West Bend, WI 53095
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Physician Statement

Name of Employee: _____

I have examined the above named individual and found him/her to be free from health conditions and free of communicable diseases which would be of potential risk to patients or which might interfere with the performance of his/her duties as a healthcare worker.

Signature of Physician: _____ Date: _____

Print name of Physician: _____

Address of Physician: _____

Phone Number of Physician: _____