HEALTH EXAMINATION FORM
Sac and Fox Nation Social Services

Last Name | First Name | Middle Name | Sex | Age

Address | City | State | Zip

FOR PHYSICIAN ONLY:

1. Patient's Complaint: _____

2. Diagnosis: _____

3. Comment on patient's ability to perform gainful employment: _____

4. Recommendations for treatment by physician (indicate if a special diet is recommended):

5. Has the patient been adhering to the prescribed treatment? YES_____NO_____

6. Approximate length of continued incapacity (please circle one):

   Short-term (1-3 months) Long-term (4-6 months) Indefinite

7. Employability of patient (please check one):

   Unable to work _____ Light duty_____ Full duty _____

8. Can the patient be made employable by the recommended treatment? _____

THIS FORM WILL ONLY BE ACCEPTED IF SIGNED BY A MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHIC MEDICINE (D.O.).

Physician's Address

City, State, Zip

Phone Number (with area code)

Physician's Signature

Date of Signature