

Physician Certification Statement of Good Health

Where Dignified Care Meets Excellence

Required by Florida Nurse Registry statute. Must be completed by an MD, DO, APRN, or PA, dated within the last 6 months, confirming freedom from communicable diseases including tuberculosis. Must be renewed annually.

NURSE / CONTRACTOR INFORMATION

Full Legal Name:

Credential:

Date of Birth:

FL License #:

Home Address:

Phone:

EXAMINATION DETAILS

Date of Examination:

Valid Through (6 months):

PHYSICIAN CERTIFICATION

I, the undersigned licensed healthcare provider, hereby certify that I have examined the above-named individual and find that he/she appears to be **free from apparent signs or symptoms of communicable diseases, including tuberculosis (TB)**, and is physically capable of performing the duties of a healthcare professional. This examination was conducted in accordance with applicable standards of care.

- Patient appears free from communicable diseases
- TB skin test (PPD) — Negative Date: _____ Result: _____
- Chest X-Ray (CXR) — Date: _____ Result: _____
- Patient has active communicable disease (specify below — **DO NOT clear for patient care**)

Additional Comments / Restrictions / TB Results:

PROVIDER INFORMATION & SIGNATURE

Provider Full Name:

Credential
(MD/DO/APRN/PA):

Practice / Facility
Name:

NPI Number:

Address:

Phone:

Provider Signature:

Date:

Please return this completed form to: info@opuluxern.com · Opuluxe Tailored Nursing · opuluxenursing.com