



Medical Clearance Form

Rev 01
Effective: 8/21/2022
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Name:

First Name

Middle Name

Last Name

Date of Birth:

MM

DD

YY

Doctor:

First Name

Middle Name

Last Name

Physicians Office / Name of Practice

Address

Address 2

City

The above applicant has applied for employment with Abba's Caring Hands, Inc. The job entails providing assistance as needed, and as appropriate in activities of daily living such as dressing, toileting, changing diapers, feeding, bathing. This may include transferring in/out of a wheelchair, etc.

By completing the form below, however, you are indicating that this employee can fulfill the duties listed above. **If you know of any medical or other reason why employing this individual would be unwise, please indicate so on this form.**

If you have any questions about the duties that this individual will be performing, please call the office and ask to speak to the Hiring Manager at (323) 702-2444

TO BE COMPLETED BY THE PHYSICIAN (Report of Physician)

PLEASE WRITE LEGIBLY

- I know of no reason why the applicant should not be employed.
- I believe the applicant can be employed, but I urge cation because:

- I believe that the applicant should not employed for this position, as they are unable to fulfil the duties listed above.

Physician's Name:

Physician's Signature:

Date

Email completed form to Abbascainghands@gmail.com