University of Tennessee Health Science Center
Graduate Medical Education Program

# Health Statement

**Trainee Name:** ________________________________________

**Date of Examination:** __________________________________

I certify that I have examined the trainee listed above and that he/she is in good health and should be able to physically and mentally perform the duties related to his/her appointment as a resident or fellow in the University of Tennessee Graduate Medical Education Program.

**Physician's Name:** __________________________________
*(Must be signed by a licensed U.S. physician. NP's only permitted from University of Tennessee University Health Services.)*

**U.S. Medical License State:** ___________________________

**U.S. Medical License Number:** _________________________

**Office Address:** _____________________________________

__________________________________________________

**Phone Number:** _____________________________________

**Signature:** ________________________________________

**Date:** ____________________________________________