

The University of Tennessee
Graduate Medical Education Program

Health Statement

Resident Name: _____

Date of Examination: _____

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

Physician's Name: _____

U.S. Medical License State: _____

U.S. Medical License Number: _____

Office Address: _____

Phone Number: _____

Signature: _____

Date: _____