THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
HUMAN RESOURCES
1960 LANDINGS BOULEVARD, SARASOTA, FLORIDA 34231
PHONE (941) 927-9000 FAX (941) 927-4020

PHYSICIAN STATEMENT OF HEALTH

Applicant Name (Print) _____ Date _____

Work Location _____ Position Title _____

I hereby authorize the use and/or disclosure of my individually identifiable health information to the Sarasota County School Board Human Resources Department as described below. I also authorize the Physician to communicate with the Human Resources Department as necessary to clarify the basis for any responses provided. I understand that this authorization is at my request and that the information is to be used to evaluate my fitness for a position with the School Board. It is not a condition of any treatment other than this evaluation. I also understand that the released information may be redisclosed and may no longer be protected by the federal privacy regulations. This authorization will expire in one year. I understand that I may revoke this authorization at any time by providing written notice to the Physician identified below, but that my revocation will not affect any actions already taken in reliance of this authorization.

Applicant Signature _____

PHYSICIAN COMPLETE THIS SECTION

The relative physical condition of the examinee is classified by the letters A, B, C, and D as follows:

☐ "A" No significant defects

☐ "B" Minor defects
Physically fit for any position, but having temporary, curable, or correctable defects, which should not interfere with position for which employed; for example, slight or moderate caries, infected tonsils, slightly defective vision, slight or moderate varicocele, mild dysmenorrhea, and other similar defects.

☐ "C" Severe defects
Those should be attended to at once, if examinee wishes to be considered eligible for position; for example, open wounds, serious systemic disease, serious gynecological conditions, large symptomatic hernias, vision less than 20/40 in either eye, 25% hearing loss, etc.

☐ "D" Unfit for position
Defects are non-correctable; has incapacitating disease or deformity; or potential public health hazard.

Physician Stamp (Below)

_____
Physician Name (Print)

Phone _____

Address _____
Street City State Zip

_____ _____
Physician Signature Examination Date

Distribution: Original – Human Resources Yellow – Applicant

RET: Master, 25FY aft sep/term, GS1-SL 19
Dupl., OSA