TENNESSEE PHYSICIANS' QUALITY
VERIFICATION ORGANIZATION, LLC

Response May Be Mailed or Faxed
Fax: (423) 495-1190; toll free: (877) 309-0933

To:

1st

2nd

3rd

FAX:

From:

HEALTH STATEMENT

NAME: _____

SPECIALTY: _____

Date of Birth: _____

The above-named health care professional is applying for medical staff appointment or reappointment or panel membership at a participating hospital(s) or managed care organization contracted with Tennessee Physicians' Quality Verification Organization, and has given your name as the physician that performed his/her last physical examination (within the past two years). Please complete the information below and return it at your earliest convenience. A return envelope is provided for your convenience. Thank you for your cooperation.

I attest that _____
has no physical or mental condition that would/could affect his/her ability to exercise safely and competently in the specialty stated above.

Date you performed last physical examination on this individual

DATE OF EXAM: _____

_____ _____
Physician's Signature Today's Date

_____ _____
Please Print Name Specialty

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