

PHYSICIAN'S STATEMENT*

FROM: PHYSICIAN: _____
STREET ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE NUMBER: _____

TO: FIRST STEP FARM OF WNC, INC.
PO BOX 1450
CANDLER, NC 28715

I HAVE EXAMINED THIS PATIENT:

NAME: _____
DOB: _____ Male _____ Female _____
SOCIAL SECURITY#: _____

AND FOUND THAT HE/SHE IS PHYSICALLY FIT, ABLE TO PARTICIPATE IN THE PROGRAM AT First Step Farm of WNC, Inc. AND IS CAPABLE OF PERFORMING UNRESTRICTED STRENUOUS FARM LABOR.

A TUBERCULOSIS TEST WAS PERFORMED ON _____ AND THE TEST RESULTS ARE: _____.

THIS PERSON IS STABLE ON THE FOLLOWING MEDICATIONS; AND MAY SELF-ADMINISTER THE SAME:

DATE BEGAN	MEDICATION NAME	STRENGTH	ADMINISTER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SIGNATURE (MUST BE M.D., F.N.P, or P.A.)

DATE

*THIS FORM MUST BE COMPLETED IN FULL, WITH PHYSICIAN'S NAME AT TOP, EITHER PRINTED OR STAMPED. (FSF 09-01-2009)