



Peoria Medical Society

7700 N. Harker Drive, Suite D

Peoria, IL 61615

Ph: 309-692-1192 Fax: 309-692-2502

RE: _____
(Applicant's name)

I have examined the above named applicant and have found the applicant's health status to be satisfactory without any condition that would interfere with his/her ability to render patient care at any of the following facilities: Center for Health Ambulatory Surgery Center, LLC., Human Service Center, Graham Hospital, Methodist Medical Center of IL, Peoria Ambulatory Surgery Center, Peoria Day Surgery Center, Perry Memorial Hospital, Proctor Health Systems Inc, Proctor Hospital, OSF Saint Francis Medical Center, OSF Saint James-John W. Albrecht Medical Center, Renal Care Associates.

I further state I am unaware of any condition that would place a patient at risk while under his/her care or that warrants review by the appropriate authority at any of the preceding facilities.

(Note: Confirmation of applicant's health status must be within the past 12 months by a licensed physician in a primary care practice. (Specialties: can be Family Practice, Internal Medicine and/or Ob/GYN specialty)

Date of Examination

Print Physician's Name

Signature of Examining Physician

License Number (required)

Date of Signature

Phone

(See attached for explanation of medical conditions – if applicable)



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RE: _____
(Applicant's name)

1.) Describe this medical condition: _____

2.) To what extent, if any, does or could this condition affect his/her current ability to practice medicine in the practitioner's current specialty area or to perform a full range of clinical activities?

2.) What is the current status of his/her conditions? _____
