FIRST STEP FARM OF WNC, INC. PHYSICIAN'S STATEMENT

FROM: PHYSICIAN: _____

STREET ADDRESS: _____

CITY. STATE, ZIP: _____

PHONE NUMBER: _____

TO: FIRST STEP FARM OF WNC, INC.
P. O. BOX 1450
CANDLER, NC 28715-1450

I HAVE EXAMINED THIS PATIENT:

NAME: _____

DOB: _____ MALE _____ FEMALE _____

SOCIAL SECURITY #: _____

I FOUND THIS PATIENT IS PHYSICALLY FIT; ABLE TO PARTICIPATE IN FIRST STEP FARM PROGRAMING; IS CAPABLE OF PERFORMING UNRESTRICTED STRENUOUS FARM LABOR; HAS THE CAPACITY FOR UNSUPERVISED TIME AWAY FROM FSF PROGRAM FOR UP TO 10 HOURS DURING WORK WEEK; UP TO 34 HOURS ON WEEKENDS; AND ON THERAPEUTIC PASSES AS DEEMED APPROPRIATE BY THE FSF PROGRAM DIRECTORS.

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

THIS PERSON MAY SELF-ADMINISTER MEDICATION:

THIS PERSON IS PRESCRIBED THE FOLLOWING MEDICATIONS:

DATE BEGAN	MEDICATION NAME	STRENGTH	ADMINISTERATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____

SIGNATURE (MUST BE M.D.) DATE

FSF 08-28-2012 FORM MUST BE COMPLETED IN FULL, PHYSICIAN'S NAME AT TOP (PRINTED OR STAMPED)