FAX COVER SHEET
Medical Record Transfer to the Student Health Care Center

TO: Student Health Care Center OCCMED
University of Florida
Attn: Preplacement Health Assessment Coordinator
PH: (352) 392-0627
FAX: (352) 846-2003

DATE: _____

FROM: _____ Typed Name of Physician

_____ City, State Zip

_____ Address

_____ Telephone #

_____ Address

_____ State License #

SUBJECT: Preplacement Health Assessment for: _____

_____ Position Number

Please find the enclosed record of the preplacement health assessment done at the request of

_____ (supervisor) from the _____ (department/research center).

This assessment was done on _____ (date, which must be within 60 days of this transfer date). The record includes the physical exam and medical history information as well as all relative forms.

RELEASE STATEMENT FOR TRANSFER OF MEDICAL RECORDS

I authorize the release of my health assessment medical records to the University of Florida's Student Health Care Center.

_____ Candidate's Name (Typed)

_____ Candidate's Signature

_____ Date

Revised 11/09