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) 294-5700
EMAIL: OccMedClinic-RiskAssessment@ahc.ufl.edu

DATE: _____

FROM: _____ _____
Typed Name of Physician | City, State Zip

_____ _____
Address | Phone #

_____ _____
Address | State License #

SUBJECT: Preplacement Health Assessment for: _____

_____
Position Number / INOP

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.

_____ _____ _____
HR Representative's Name | HR Rep Phone # | HR Representative's Email Address

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 (Printed) | Candidate's Signature | Date