DIOCESE of TULSA
and Eastern Oklahoma

12300 E. 91st St. South, Broken Arrow, OK 74012
P.O. Box 690240, Tulsa, OK 74169-0240

# PHYSICIAN'S STATEMENT OF GOOD HEALTH

*This form must be completed and signed by a physician.*

Name of the Applicant: _____ Date of Birth: _____

Statement of Good Health

I, the undersigned, a physician duly licensed for the practice of medicine, hereby certify that I have examined the Applicant. According to my professional judgment, the Applicant is in good physical and mental health. I am unaware of any mental illness or other adverse health conditions involving changes in emotion, thinking or behavior in the Applicant.

Physician comments (if any): _____

_____

_____

_____

I certify that the above information is true to the best of my ability.

Signature of the Physician: _____

Name of the Physician: _____

Address of Office: _____

_____

Phone Number: _____

Date: _____

Physician Stamp (if any): _____