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) 294-5700
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