

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

TO: Student Health Care Center OCCMED DATE: _____
University of Florida
Attn: Preplacement Health Assessment
Coordinator
PH: (352) 294-5700
FAX: (352) 846-2003

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
