Medical Records Release

I, _____, acknowledge and understand that Competent Nursing Staff, LLC and its client facilities require medical documentation reasonably necessary to make decisions regarding my employment. I agree to provide all requested medical documentation relating to any requested or required accommodation to Competent Nursing Staff, LLC. I authorize Competent Nursing Staff, LLC to share requested medical documentation with the company's affiliates and client facilities. Neither Competent Nursing Staff, LLC, nor its client facilities will further disclose medical documentation released pursuant to this authorization, unless further expressly authorized by me or required by law. This authorization shall become effective immediately and shall remain in effect for three (3) years. I understand that I have the right to receive a copy of this authorization up
on request.

_____ _____
Healthcare Professional Signature Date

_____ _____
Healthcare Professional Name Printed Date

Work- Related Allergies and Accommodations *(At least one box must be checked)*

☐None ☐Powder ☐Latex ☐Other: _____

Accommodations/Limitations *(required if powder/latex/other were checked above, check all that apply)*

☐Latex-Free Gloves ☐Powder-Free Gloves ☐Latex & Powder Free Gloves