



# Peoria Medical Society

7700 N. Harker Drive, Suite D

Peoria, IL 61615

Ph: 309-692-1192 Fax: 309-692-2502

RE: \_\_\_\_\_  
(Applicant's name)

I have examined the above named applicant and have found the applicant's health status to be satisfactory without any condition that would interfere with his/her ability to render patient care at any of the following facilities: Center for Health Ambulatory Surgery Center, LLC., Human Service Center, Graham Hospital, Peoria Ambulatory Surgery Center, Peoria Day Surgery Center, OSF Saint Francis Medical Center, OSF Saint James-John W. Albrecht Medical Center, Renal Intervention Center and UnityPoint Health – Methodist Medical Center, UnityPoint Health – Proctor Hospital, and Proctor Health Systems Inc.

I further state I am unaware of any condition that would place a patient at risk while under his/her care or that warrants review by the appropriate authority at any of the preceding facilities.

**(Note: Confirmation of applicant's health status must be within the past 12 months by a licensed Advanced Practice Nurse, Physician Assistant or a Physician in a primary care practice. (Specialties: can be Family Practice, Internal Medicine and/or Ob/GYN specialty)**

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Print Practitioner's Name

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
License Number (required)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Phone

(See attached for explanation of medical conditions – if applicable)



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RE: \_\_\_\_\_  
(Applicant's name)

1.) Describe this medical condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2.) To what extent, if any, does or could this condition affect his/her current ability to practice medicine in the practitioner's current specialty area or to perform a full range of clinical activities?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2.) What is the current status of his/her conditions? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_