For Healthcare Facility

Medical Fitness Declaration Form

Name of Institution/Healthcare facility	

Dear QCHP,

I, the undersigned _____, the Medical Director of healthcare facility hereby declares that the Institution/healthcare facility shall be fully responsible for medical fitness to Practice for our healthcare practitioners who are seeking to renew their license. QCHP will not be held liable in this regards. We shall notify QCHP immediately in an event of any medical fitness issues. We also acknowledge that that necessary documents/evidence should be available upon request by QCHP.

Signature (Medical Director)

Facility Stamp

Date: _____

For Practitioner

Medical Fitness Declaration Form

Name of Practitioner	
License Number	
Name of Institution/Healthcare Facility	

Dear QCHP,

I, the undersigned _____, the healthcare practitioner seeking to renew my license would declare that I am medically fit to practice and would notify QCHP in case of any medical incidents such as communicable diseases. I am aware that failure to make a full declaration of health condition may lead to removal of my registration and license to practice.

Practitioner Signature

Practitioner Stamp (if applicable)

Date: _____