Self-Determination Provider
Annual Health Review

Provider Name: _____

Individual's Name: _____

☐ During the past year my health status has not changed

☐ During the past year my health status changed as it relates to my ability to do the job for which I was hired. Following is an explanation of my current health status:

_____
_____
_____
_____
_____
_____
_____

_____ _____
Provider Signature Date

This employee health review is completed according to the requirements of the Department of Community Health.

This is to state that, together with the above named Self Determination provider, I have reviewed his/her health status on this date.

_____ _____
Individual/Guardian Signature Date