DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

EASTERN COLORADO HEALTH CARE SYSTEM

Declaration of Health

I, _____ hereby declare that, to the best of my knowledge, I do not have a physical or mental health condition that would adversely affect my ability to carry out my duties at the Department of Veterans Affairs Medical Center/ECHCS, Denver, CO.

_____ _____

Name of the Employee **Date**

_____ _____

Signature of Practitioner **Date**