



Office of the



State Superintendent of Education

STAFF HEALTH CERTIFICATE

Name: _____

Sex: Male Female

Date of Birth: _____

Telephone No: _____

Address: _____

I have examined the above-named person and certify that he/she is:

- Free from disease in communicable form.
- Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to adults.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): Tine PPD

Date: _____ Result: _____

Chest X-Ray: Date: _____ Result _____

Remarks: _____

Signature of Examining Physician/Nurse Practitioner MD/NP

Date of Examination: _____

Address

Telephone No.: _____
(Area Code)