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: _____

_____

_____

_____ MD/NP Date of Examination: _____
Signature of Examining Physician/Nurse Practitioner

_____ Telephone No.: _____
Address (Area Code)

810 First Street, NE, 4th floor, Washington, DC 20002
Phone: 202.727.1839 • Fax: 202.727.8166 • www.osse.dc.gov