HEALTH EXAMINATION CERTIFICATE **North Carolina Public Schools**

Required of all persons upon initial employment, separation from employment more than one school year, absence of more than 40 successive days because of a communicable disease, or when deemed necessary by a local school board or superintendent. (Ref. NCGS 115C-323)

Name: ____

Social Security Number: ____________________ Employee ID Number ____________________

Address: ____

The above named individual is to be recommended for employment by the ____________________ in a position of ____________________. In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

I. Communicable Disease **Please enter TB Skin Test Results ____________________**

By my signature I certify that the above **named person does not have any communicable disease, including tuberculosis** that poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted below. Further, I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

____

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II. Other Health Areas

AREAS	LIMITATIONS YES	NO	NATURE OF LIMITATIONS (continue on back as needed)
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			

Appropriate Immunizations	Current? YES	NO	Any Immunization Recommendations
Td (tetanus), Hep B, MMR, etc.			

Date: ____________ ____

Physician, Physician's Assistant, or Nurse Practitioner (Type or Print)

SIGNATURE: ______________________________

License/Registration #: ____________________ State* Granting License/Registration: ____________

*For initial employment of an out-of-state applicant, the certificate may be completed by a health care provider with an out-of-state unrestricted current license or registration.