HEALTH CERTIFICATE

Any person initially employed in a public school, or re-employed after an absence of more than one school year, shall file with the human resources office a certificate certifying that the person does not have any physical or mental disease, including tuberculosis in the communicable form or other communicable disease, that would impair the person's ability to perform his or her duties effectively.

Any public school employee who has been absent for more than 40 successive school days because of a communicable disease must, before returning to work, file with the human resources office a certificate certifying that the individual is free from any communicable diseases.

The certificate required by this policy must be prepared by:

1. a physician licensed to practice in North Carolina,
2. a nurse practitioner approved under G.S. 90-18(14), or
3. a physician's assistant licensed to practice in North Carolina.

In the case of a person initially employed in a public school, any of the following who holds a current, unrestricted license or registration in another state may prepare the certificate:

1. a physician,
2. a nurse practitioner, or
3. a physician's assistant

so long as evidence of the license or registration is on the certificate. The health certificate form is available in the human resources office.

LEGAL REF: G.S. 115C-323
ADOPTED: May 13, 1996
REVISED: December 15, 2008

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: _____
Address: _____
_____

The above named individual is to be recommended for employment by _____ (local school board) 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

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:

_____

_____

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.

1/2002