HEALTH EXAMINATION CERTIFICATE — Cumberland County 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 **Cumberland County Schools** (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, **(TB test required)** 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			

TB SKIN TEST/PPD	DATE GIVEN	DATE READ	RESULTS

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 provided with an out-of-state unrestricted current license or registration.