



This form meets Ohio Administrative Code. Programs may use this form or build their own.

Section I - Medical Provider Information

Physician/Clinic/Hospital Name _____ Provider Address _____
Provider Phone Number _____ City _____ State _____ Zip _____

Section II - Medical Statement Verification

Employee Name _____

Certify Employee Medical Status:

- Free of Communicable Disease
Fit to work with children in the following age groups:
Infant/Toddler
3 years - 14 years

Screened for Tuberculosis (TB)

- Has the employee resided in a country identified by the world health organization (WHO) as having a high burden of tuberculosis (TB)? Yes No
Has the employee arrived in the United States within the five years immediately preceding the date of application for employment? Yes No

Employment Application Date: _____

If the answers to both questions above are yes, the individual is required to be tested for TB.

TB Test Date: _____ TB Test Results: Negative Positive

Check box of examining medical professional:

- Physician Physician Assistant Advanced Practice Registered Nurse

Signature of Medical Professional _____ Date _____

I verify that the information presented on this form is accurate and complete.