

## North Carolina Public Schools HEALTH EXAMINATION CERTIFICATE

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

Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_

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.

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

By my signature I certify that the above named person does not have any communicable diseases, 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 above. Further, I certify that this person is free of any other physical or mental disability that would impair job performance.

If unable to certify the above, please comment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Name (type or print)*

\_\_\_\_\_  
*Signature of Physician* **M.D.**