OSSE

DC Office of the State Superintendent of Education

STAFF/VOLUNTEER HEALTH CERTIFICATE

Name: ____________________ Sex: ☐ Male ☐ Female

Child Development Facility Name: ____________________

Date of Birth: ____________________ Telephone No. ____________________
Area Code

Home Address: ____________________
Number Street Apt. (if applicable) City State Zip Code

I have examined the above-named person and certify that he/she:

- Is free from disease in communicable form
- Appears to be in satisfactory physical and mental health condition, capable of doing physical household tasks, supervise and give care to children.

In addition to a general physical health examination, the following tests have been done:

Tuberculin test (Check One): ☐ PPD ☐ Chest X-Ray

Date ____________ Result ____________ Signature of Recorder ____________________

Remarks: ____________________

____

MD/NP

____
Signature of Examining Physician/Nurse Practitioner

____
Date of Exam

____
Address

____
Area Code & Phone Number

PLEASE RETAIN A COPY FOR YOUR RECORDS

825 North Capitol St NE, 2nd Floor Suite 2224 Washington, DC 20002 (202)442-4780 Fax (202)442-9430