



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

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.

Effective July 1, 2009, staff medical statements must be on file and updated on a regular basis according to program policy.