



DISTRICT OF COLUMBIA  
OFFICE OF THE STATE SUPERINTENDENT OF

# EDUCATION

## STAFF/VOLUNTEER HEALTH CERTIFICATE

*(To be completed by medical professional)*

*Title 5A DCMR Chapter 1, 131-5 (c) - A Licensee shall maintain a record for each staff member, including paid employees and volunteers whose activities involve the care or supervision of children at a facility or unsupervised access to children who are cared for or supervised at a facility, which shall include written and signed documentation from the examining licensed health care practitioner, at the time of his or her examination, that the staff member or volunteer was free from tuberculosis and apparent communicable diseases as defined in 22-B DCMR § 201.*

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

Sex: \_\_\_Male \_\_\_Female

Date of Birth: \_\_\_\_\_

Telephone No: \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street Apt.(if applicable) City State Zip Code

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

- Completed a pre-employment physical examination by a licensed health care practitioner, conducted not more than twelve 12 months prior to the start of employment or volunteer work;
- Had an annual physical examination by a licensed health care practitioner;
- At the time of his/her examination is free from tuberculosis and apparent communicable diseases;
- Appears to be in satisfactory physical condition, capable of performing activities with children for extended periods of time, and be outdoors for regular, prolonged activities.

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

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

Date: \_\_\_\_\_

Result: \_\_\_\_\_

Remarks: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Examining Physician/Nurse Practitioner

MD/NP

Date of Examination: \_\_\_\_\_

\_\_\_\_\_  
Address

Telephone No.: \_\_\_\_\_  
Area Code

**PLEASE RETAIN A COPY FOR YOUR FILES.**