Ohio | Department of Education

Office of Early Learning and School Readiness
Employee Medical Statement
Revised 6.8.2021

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.

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