GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION AND LICENSING ADMINISTRATION



Health Certificate for Staff

N A M E:	_ SEX (Please circle one	e): MALE	FEMALE
DATE OF BIRTH:	TELEPHONE No:		
ADDRESS: Street	City S	itate Zij	o Code
TYPE OF PROFESSIONAL LICENS I have examined the above-named person			
1. Free from disease in communication	ole form. {Please Circle On	e:} YES NO)
2. In addition to a general physical l	nealth examination, the follo	owing test have b	een done:
Tuberculin Test (check one)	[] Tii	ne [] PPD	
Date:	Result: _		
Chest X-Ray, Date:	Result: _		
Remarks:			
Signature of Health Care Practitioner		Date of Ex	xamination
Address of Health Care Practitioner		Telephon	e No.