SUMMIT COUNTY EDUCATIONAL SERVICE CENTER
Student Services Department
420 Washington Ave.
Cuyahoga Falls, Ohio

EMPLOYEE MEDICAL STATEMENT

Date _____

Name of employee *(please print)*_____ is

- Free of communicable diseases, and
- Physically fit to work with children age birth – age 15.

Limitations: _____

_____

_____

_____
Signature of examining *(check which applies)*

☐Physician ☐Physician's Assistant or ☐Advance Practice Nurse

_____
Date of exam

Name of Physician/Clinic/Hospital *(please print)* _____

Street Address _____

City _____ State _____ Zip _____

Phone number _____

NOTE: Effective July 1, 2009, staff medical statements must be on file and updated on a regular basis according to program policy. The medical statement can be completed by a physician, a physician's assistant, clinical nurse specialist, or a certified nurse (Rule 3301-31-04 (E)).