

North Carolina Public Schools Student Teaching/Graduate Internship Health Examination Certificate

Required of all persons upon initial employment, or separation from employment more than one school year, or deemed necessary by a local school board or superintendent. This certificate must be completed and signed by a physician licensed to practice medicine in the State of North Carolina (NCGS §115C-323). *For student teaching purposes, this information may be provided by an out-of-state physician.* **School systems will not officially acknowledge your student teaching assignment and may not allow you to report to your school until your completed health form has been filed.**

Name: _____

UNC PID: _____ Licensure Area: _____

UNC Address: _____

_____ UNC Telephone: (____) _____

E-mail Address: _____ / _____

University

Personal/home

The above named individual is to be recommended by UNC-Chapel Hill, School of Education for the position of student teacher/graduate intern. In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

(HEALTH FORM IS VALID FOR 1 YEAR ONLY)

AREAS	LIMITATIONS		NATURE OF LIMITATIONS
	<i>YES</i>	<i>NO</i>	
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			
Other			

TB Test Information

Test Date: _____

(The test date must be within one year of beginning date student teaching.)

Result (circle one): **POSITIVE** **NEGATIVE**

Name of person administering TB test (*Please type/print*)

Telephone Number

Signature: _____

By my signature I certify that the above named person does not have any communicable disease, including tuberculosis, which poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted above. Further I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify, please comment on the back of this form.

Physician's name (*please type/print*) _____

Physician's Signature _____

Telephone number (____) _____ Fax (____) _____

This form must be returned to Janice Gattis, 103C Peabody Hall, by July 31, 2009